



The Center for Integrative Healthcare & Healing

Integrative Healthcare Intake Form

Name _____ Date of Birth _____ Date _____

What brings you in to see us today? _____

Who referred you/how did you hear about us? _____

What would you like to address today?

	<u>Concern</u>	<u>Onset</u>	<u>Frequency</u>	<u>How this impacts your life</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Please describe your previous experiences with alternative or complementary medicine (e.g. acupuncture, naturopathy, massage therapy, Reiki, hypnotherapy, etc)

Mind/Body

With whom do you live? _____

What pets do you live with? _____

Do you feel safe in your home? _____

What is your occupation? _____

Are you, or were you, married or partnered? _____

What are the ages of your children? _____

Who are the most important people in your life? _____

PERSONAL MEDICAL HISTORY

Please list any surgical procedures/operations/major injuries:



PERSONAL MEDICAL HISTORY (continued)

Please check the following conditions that apply to you and circle appropriate choices when given.

- | | |
|---|---|
| <input type="checkbox"/> Alcoholism or Substance Abuse | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> History of Infertility |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Infections/Stones |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer (Type _____) | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Seizures, Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Serious Injury/Accident (Type _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sexually Transmitted Disease
(Chlamydia, Warts, Herpes) |
| <input type="checkbox"/> Digestive (Crohn's, IBS, Ulcerative Colitis) | <input type="checkbox"/> (Specify Other _____) |
| <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent Sinusitis | <input type="checkbox"/> Thyroid Disease (Specify _____) |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Urinary Problems (Incontinence, Infections) |
| <input type="checkbox"/> Hay Fever, Allergies, Eczema | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Heart Attack, Heart Disease, Heart Failure | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Headaches (Migraines, Tension) | <input type="checkbox"/> Other (Specify) _____ |

WOMEN ONLY

Reproductive History

- Age at first menstrual period _____
Date of last menstrual period _____
Usual Flow: _____ Heavy _____ Moderate _____ Light
Length of period in days _____
Number of days between periods _____
Do you have (please circle): Painful Periods, Missed Periods,
Spotting between Periods, Vaginal Bleeding, Unusual
Discharge/Infections, Recurrent Vaginal Infections
If you have gone through menopause, have you had any
post-menopausal bleeding? _____
Date of last Pap smear _____
History of Abnormal Pap smears? _____
Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____
Sexual Orientation: _____ Heterosexual _____ Homosexual _____ Bisexual _____ Transgender

Contraceptive History (Please circle)

- Birth Control Pills Type _____ Duration _____
Diaphragm/Cap Type _____ Size _____
IUD Type _____ Last Change _____
Norplant, Condom and/or Foam, Suppository
Tubal Ligation, Hysterectomy, Partner with Vasectomy
Other _____
Problems with current method _____



MEN ONLY

Do you have: _____ Prostate Problems _____ Sexual Dysfunction (low libido, impotence)
 _____ Vasectomy _____ Testicular Cancer

Sexual Orientation: _____ Heterosexual _____ Homosexual _____ Bisexual _____ Transgender

REVIEW OF SYSTEMS

Please check or circle any of the following symptoms that apply to you.

General
Fatigue
Difficulty sleeping
Weight loss or weight gain
Eyes/Ears/Nose/Throat/Sinuses
Blurred vision
Hearing loss or ringing in ears
Frequent infections
Pain
Frequent throat clearing or post-nasal drainage
Heart/Circulation
Chest discomfort (pain/pressure/tightness)
Palpitations
Leg swelling
Lungs
Shortness of breath
Wheezing
Cough
Digestion/Elimination
Heartburn/Reflux
Nausea/Vomiting
Abdominal bloating
Abdominal pain/cramping
Excessive belching or gas
Constipation
Diarrhea
Kidneys/Bladder/Urination
Urgency or increased frequency
Pain or burning with urination
Difficulty urinating
Blood in the urine
Leakage
Frequent infections

Muscles/Bones/Joints
Muscle pain
Muscle cramps or spasms
Joint pain/stiffness/swelling
Low back pain
Neck pain
Other:
Nervous System
Headaches
Dizziness
Balance problems
Weakness/Numbness/tingling
Difficulty concentrating
Memory problems
Allergies/Immune System
Seasonal allergies
Food allergies
Other:
Hormonal/Endocrine
Cold or heat intolerance
Night sweats
Excessive thirst
Excessive hunger
Blood
Easy bruising
Abnormal bleeding
Skin
Rashes
Eczema
Psychiatric/Psychological
Depression
Anxiety or panic attacks
Suicidal thoughts



FAMILY MEDICAL HISTORY

	List family members who have or had this illness.
Arthritis	
Alcoholism or Substance Abuse	
Cancer: Breast	
Cancer: Colon	
Cancer: Other	
Depression or other Mental illness	
Diabetes	
Glaucoma	
High Blood Pressure	
Heart Disease	
High Cholesterol	
Kidney Disease	
Liver Disease (Hepatitis, etc)	
Lung Disease (Asthma, COPD, etc.)	
Stoke	
Thyroid Disease	
Other:	
Other:	
Other:	

Lifestyle/Behavior

What are the major stressors in your life? _____

How do you relax/relieve stress? _____

What physical activity do you participate in? How often? _____

What leisure activities/hobbies do you enjoy? _____

Do you have a spiritual or religious practice? _____

What brings meaning to your life? _____

Describe your sleep patterns. _____

Describe your overall energy level. _____



	Amount Per Day	Amount Per Week	Never Used
<u>Tobacco</u>			
Cigarettes	_____	_____	_____
Cigars/Pipe	_____	_____	_____
Chewing	_____	_____	_____
<u>Alcohol</u>	_____	_____	_____
<u>Recreational Drugs</u>	_____	_____	_____

NUTRITION

How many meals do you eat per day? _____

Who does the food shopping in your home? _____

Who prepares the food in your home? _____

How often do you cook? _____

Which meals do you regularly eat outside your home? _____

Are you currently on a special diet? _____

Do you have any sensitivities to food or avoid any foods? _____

How often to you eat fast food? _____

Which foods do you regularly crave? _____

What and how much do you drink on a typical day? _____ water _____ caffeine _____ other

How would you describe your relationship with food? _____

Please provide an overview of your current diet to help us assess your nutritional needs. In each category, provide the type and amount you consume weekly. (EXAMPLE: FRUITS - bananas, apples, blueberries, grapes, etc.)

FRUITS _____	DAIRY _____
VEGETABLES _____	FISH _____
BEANS _____	MEATS _____
SALAD GREENS _____	BREADS _____
NUTS/SEEDS _____	CEREALS _____
GRAINS _____	PASTA _____
OILS _____	SOY PRODUCTS _____
BEVERAGES _____	SNACKS _____



MEDICATIONS

What medications are you currently taking? (Include prescription drugs and over the counter drugs.)

<u>Medication</u>	<u>Dose</u>	<u>Reason for Use</u>	<u>When Started</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What vitamins/minerals/herbal supplements are you currently taking?

<u>Brand or Other Name</u>	<u>Dose</u>	<u>Reason for Use</u>	<u>When Started</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any other information that you would like us to know? _____

“It is more important to know what sort of patient has a disease than what disease a patient has.”

Sir William Osler





Connecticut Multispecialty Group, P.C.
Leaders in Integrated Medical Care

The Center for Integrative Healthcare & Healing

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____ Other name records may be kept under: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ - _____ - _____ Home Phone: () _____ Work Phone: () _____

Cell: () _____

May we leave confidential voice-mail messages for you at any of the above numbers? No Yes Specify which: H W C

Email: _____ May we send newsletters to you by email? No Yes

Your Employer: _____ If student, school or college: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Insurance Information (Complete only if you are not the insured)

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ SS#: _____ Date Employed: _____

Name of Employer: _____ Work Phone: _____

Responsible Party (Complete if someone other than patient is responsible for account)

Name: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

Cell Phone: _____ Email: _____ Currently a patient here? Y N

I hereby authorize payment of insurance benefits directly to Dr. Goodman. I am responsible for any deductibles, copayments and retroactive fees not covered by my insurance policy.

X _____

Signature of patient or parent/guardian if minor

Date

CONSENT FOR TREATMENT

General Information: Due to the diversity of modalities offered at this office, your treatment may include any or all of the following general modalities: Acupuncture, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.

Methods, Procedures and Therapeutic Approaches: Your clinician may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments).

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Acupuncture: (insertion of special sterilized needles at specific points on the body)

Topical Treatments and Prepping (includes cupping --a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha--rubbing on an area of the body with a blunt, round instrument)

Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes; suppositories

or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment.

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy)

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Jonathan Goodman regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

This office may disclose your health care information to other health care professionals for the purpose of treatment.

Payment

This office may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Emergencies

This office may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or your death,

Public Health

As required by law, this office may disclose your health information to public health authorities for purposes related to: preventing or controlling disease. Injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

This office may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

This office may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

This office may disclose your health information to coroners or medical examiners.

Organ Donation

This office may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

This office may disclose your health information to researchers conducting research that has been approved by an institutional review board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person to the general public.

Specialized Government Agencies

This office may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

This office may from time to time distribute post cards reminding patients of the need to update their diagnostic test information or schedule an appointment. Also, newsletters may be sent to patients providing up-to-the-minute information about matters relating to natural medicine. It is not the practice of this office to disclose patient health information in these correspondences.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that this practice amend your protected health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of the denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by this practice.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact this office.

Complaints

Complaints about your privacy rights or how this practice has handled your health information should be directed to this office. If you are not satisfied with the manner in which this office handles your request, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of July 19, 2005.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as prescribed in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date