Capital Region PHYSICIANS
University of Missouri Health Care
Better. Every day.

Welcome to our clinic! We look forward to meeting you and caring for your health needs.

When you come for your appointment, please bring the **completed** enclosed forms, your current medications/vitamins/supplements, insurance card, and photo ID. We ask that you **arrive 30 minutes before your appointment**. If you are not able to keep your appointment, please call 48 hours in advance to reschedule.

The detailed descriptions of your health concerns will help you and your provider to design the best treatment plan for you. Several of the questions on the health form are very personal; however, they may be indicative of stressors which can affect your health. All answers will be held in strict confidence.

Thank you for choosing Integrative Medicine to participate in your health and wellness goals.

Sincerely,

Chris Link, MD
Rachel Lenon, FNP-BC
Jalyn North, MSN-FNP

Capital Region Physicians- Integrative Medicine
999 Diamond Ridge Jefferson City, MO 65109
Phone: (573)632-5585 Fax: (573) 634-2978

Directions:

From St. Louis:

1-70 West to US-54 West
Take US-54 W Exit (Kingdom City) — turn left onto US-54 W
Just after MO River Bridge take US-50 exit – 3rd exit to the right (after Main and McCarty Street Exits)
Take Exit for HWY 179 — turn left onto 179
Turn right onto West Edgewood (stoplight)
Turn right onto Diamond Ridge
We are at the top of the hill on the right in the Fisher Building. Look for the Capital Region Physicians sign then take the second entrance. Our clinic is accessed from the upper parking lot (North side of the building).

From Columbia:

US 63 South towards Jefferson City
Just after MO River Bridge take US-50 exit – 3rd exit to the right (after Main and McCarty Street Exits)
Take Exit for HWY 179 — turn left onto 179
Turn right onto West Edgewood (stoplight)
Turn right onto Diamond Ridge
We are at the top of the hill on the right in the Fisher Building. Look for the Capital Region Physicians sign then take the second entrance. Our clinic is accessed from the upper parking lot (North side of the building).

From Kansas City:

1-70 East and then from Columbia, follow the above directions.
OR
Take US-50 East toward Jefferson City
Take Exit for HWY 179 — turn right onto 179
Turn right onto West Edgewood (stoplight)
Turn right onto Diamond Ridge
We are at the top of the hill on the right in the Fisher Building. Look for the Capital Region Physicians sign then take the second entrance. Our clinic is accessed from the upper parking lot (North side of the building).

Patient Name: _____ DOB: _____

Primary Care Provider: _____ **Referring Provider:** _____

Current / Recent medical and other health care providers (Please list names; include physical therapy, psychology, etc.):

_____

_____

List Complementary and Alternative therapies or practitioners you have tried (Please list names):

_____

_____

Please describe your goals and expectations regarding your appointment with Integrative Medicine:

_____

_____

Current Medications (please include all prescriptions and over the counter drugs): ☐ **NO CURRENT MEDICATIONS**

Medication Name	**Dosage Amount** (Ex. 15 mg, 2 puffs, 5 meq)	**Take** (Ex. 1 tablet, 2 tablets 1 to 2 tablets)	**Frequency** (Ex. Once a day, Twice a day, as needed)	**Reason for Medication** (Ex. High blood pressure, diabetes, high cholesterol)

Patient's Medical History (please include detail, if applicable):

□ Anxiety	□ Depression	□ Headaches	□ Impotence	□ Seasonal Allergies
□ Asthma	□ Diabetes	□ Heart Attack	□ Infertility	□ Seizures
□ Asthma, exercise induced	□ Eczema	□ Heart Disease	□ Migraines	□ Sleep Disorder
□ Bleeding Disorders	□ Emphysema	□ Heart Murmur	□ Mitral Valve Prolapse	□ Stomach Ulcers
□ Cancer_____	□ Erectile Dysfunction	□ Hemorrhoids	□ Nerve Damage	□ Stroke
□ Cirrhosis	□ Fibromyalgia	□ Hepatitis	□ Psoriasis	□ Thyroid Disease
□ Concussion	□ Gallstones	□ High Blood Pressure	□ Rheumatic Fever	□ Tuberculosis
□ COPD	□ Glaucoma / Cataracts	□ HIV / AIDS	□ Rosacea	□ Venereal Disease
□ Other:_____				

Previous Colonoscopy: **Yes** or **No** **Date:** _____ ***Findings:*** _____
Previous Bone Density: **Yes** or **No** **Date:** _____ ***Findings:*** _____
Previous Mammogram: **Yes** or **No** **Date:** _____ ***Findings:*** _____

Immunizations up to date? **Yes** or **No** **Varicella (chickenpox)?** **Yes** or **No**
Tetanus within 10 years? **Yes** or **No** **Hepatitis B series?** **Yes** or **No**
Pnuemovax? **Yes** or **No** **Gardasil (HPV)?** **Yes** or **No**

Psychiatric History:

Have you ever been treated for emotional problems? **Yes** or **No**
Have you ever considered attempted suicide? **Yes** or **No**

Medication Allergies (List Reactions or write unknown): ☐ **NO KNOWN DRUG ALLERGIES**

_____

_____

_____

Patient Name: _____ DOB: _____

Surgical History *(Provide year of procedures):* ☐ **NO PREVIOUS SURGICAL HISTORY**

_____
_____
_____

Hospitalization(s) *(Excluding from surgery, births, or ER visits. Provide date and Reason):* ☐ **NO HOSPITALIZATIONS**

_____
_____
_____

Accidents / Trauma *(Describe and provide dates of injuries):*

_____
_____
_____

Family History *(Health Problems or Conditions)**:***

Alive	Deceased	Age of Death		High Blood Pressure	Heart Disease	High Cholesterol	Asthma	Diabetes	Stroke	Colon Cancer	Breast Cancer	Lung Cancer	Ovarian Cancer	Seizures
			Mother											
			Father											
			Sibiling(s)											
			Maternal Grandmother											
			Maternal Grandfather											
			Paternal Grandmother											
			Paternal Grandfather											
			Maternal Aunt											
			Maternal Uncle											
			Paternal Aunt											
			Paternal Uncle											
Other Family History:														

# of Siblings – Brothers _____ Sisters _____ ☐ Healthy

# of Children – Sons _____ Daughters _____ ☐ Healthy

Social History:

Have you ever smoked or used tobacco? **No** or **Formerly** or **Currently** Type: _____

How often do you smoke? _____ Amount per day: _____

If former smoker, at what age did you start? _____ Age stopped? _____

Best way to learn: ☐ Reading ☐ Listening ☐ Visual ☐ Demonstration ☐ No Preference ☐ Other: _____

Barriers to learning: ☐ Language ☐ Culture ☐ Hearing ☐ Vision ☐ Permanent Cognitive Impairment ☐ None

Patient Name: _____ DOB: _____

Social History Continued:

Have you used illicit drugs, other than for medical reasons, in the past 12 months? **Yes** or **No** Type: _____

Are you currently using? **Yes** or **No** Date of last usage: _____ Age you started using? _____

Did you have a drink containing alcohol in the past year? **Yes** or **No**

If yes, how often did you have 6 or more drinks on one occasion? ☐ 2-3 times/week ☐ 4 or more times/week ☐ Monthly or Less

If yes, how many drinks did you have on a typical day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ More than 10

If yes, how often do you have a drink containing alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

# of adults in the household _____ # of children in the household _____

Occupation: _____ Occupational Exposure? **Yes** or **No** Exposure type: _____

Special Diet? **Yes** or **No** If yes, what are your restrictions? _____

Caffeine intake: ☐ Coffee ☐ Soda ☐ Tea ☐ Energy Drink ☐ None How often? _____

Exercise regularly? **Yes** or **No** How many times per week? _____ Type: _____

Describe your religion / spirituality: _____

Describe current state of finances: _____

Hobbies / Volunteer Work (current or previous): _____

Sexual History: (Answers to the following questions help your clinician provide appropriate care for you and help identify your risk for cervical cancer. Leave any questions blank if you are uncomfortable answering them. Please feel free to discuss any concerns with your clinician)

Have you ever had sexual intercourse? **Yes** or **No**

If yes, the following will apply:

Are you currently sexually active? **Yes** or **No**

Have your sexual partners been: **Men** or **Women** or **Both**

What was your age at first intercourse? _____

Total number of lifetime partners: _____ Number of lifetime partners in the last 12 months: _____

Have you had intercourse without contraception since your last menstrual period? **Yes** or **No**

Have you had intercourse without a condom since your last STD testing? **Yes** or **No**

Does your partner have any symptoms of infection? **Yes** or **No**

Have you experienced any unwanted sexual encounters? **Yes** or **No**

GYN History:

First day of last menstrual period: _____

Age at first menstrual period: _____ # of days between periods: _____ Length of periods: _____ Age at menopause: _____

Method of birth control: ☐ Condoms ☐ Oral Contraceptive ☐ IUD ☐ Shot ☐ None ☐ Other: _____

Date of last PAP: _____ Results: **Normal** or **Abnormal**

History of abnormal PAP? **Yes** or **No** Treatment: _____

Do you do self-breast exams? **Yes** or **No** Have you ever found a lump? **Yes** or **No**

OB History:

Total # of pregnancies: ___ Total # of full term deliveries: ___ Total # of pre-term deliveries: ___

Total # of miscarriage(s): ___ Total # of abortion(s): ___ Total # of ectopic pregnancies: ___ Total # of multiple birth(s): ___

Patient Name: _____ DOB: _____

Please circle any of the below items that have affected you in the past <u>6 months</u>.

General:	**Head/Eyes/Ears/Nose/Throat:**	**Gastrointestinal:**	**Musculoskeletal:**	**Neurological:**
Binge eating/ drinking Craving certain foods Excessive weight Compulsive eating Water retention Currently underweight Fatigue, sluggishness Apathy, lethargy Hyperactivity Restlessness Frequent illness Other: _____	Headaches Faintness Dizziness Insomnia Swollen/discolored tongue, gums, lips Canker sores Itchy ears Earaches, ear infections Drainage from ears Ringing in ears Hearing loss Watery or itchy eyes Swollen, reddened, or sticky eyelids Bags or dark circles under eyes Blurred or tunnel vision Stuffy nose Sinus problems Hay fever Sneezing attacks Excessive mucous formation Chronic cough Gagging/ frequent need to clear throat Sore throat Hoarseness/ loss of voice Other: _____	Nausea Vomiting Diarrhea Constipation Bloating Belching Passing gas Heartburn Intestinal/ stomach pains Other: _____	Pain or aches in joints Arthritis Stiffness or limited movement Pains or aches in muscle Feeling of weakness or tiredness Other: _____	Poor memory Confusion/ poor comprehension Poor concentration Poor physical coordination Difficulty in making decisions Stuttering/ stammering Slurred speech Learning difficulty Other: _____
Respiratory:		**Cardiovascular:**	**Skin:**	**Genitourinary:**
Chest congestion Asthma Bronchitis Shortness of breath Difficulty breathing Other: _____		Irregular heart rate Skipped heartbeat Fast/pounding heart rate Chest pain Other: _____	Acne/pimples Hives/rashes Hair loss Dry skin/ scalp Flushing/ hot flashes Excessive sweating Other: _____	Urinary Frequency Urinary Urgency Genital itch or discharge Other: _____

If you are experiencing pain now or having on-going pain please fill out the following section.

Location: _____

Quality: _____

Radiation: _____

What makes it better? _____

What makes it worse? _____

How long have you had it? _____

Mark an X on the line where your pain is currently:

No pain *Excruciating pain*

0 1 2 3 4 5 6 7 8 9 10

Please describe how your pain affects your daily activities and sleep:

_____

_____

_____

How would you describe your health (circle one): **Poor** **Average** **Good**

List the things that cause you the most stress in your life now *(e.g. relationships, family, health, money, job, etc.)* and number them in order of significance

_____

_____

_____

How would you rate your stress level in the past month? Place an X or circle the appropriate spot on the line below:

No stress *Extremely stressed*

0 1 2 3 4 5 6 7 8 9 10

How would you rate your emotional state in the past month? Place an X or circle the appropriate spot on the line below:

Unhappy *Happy*

0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____ DOB: _____

What do you do for relaxation/coping?

_____

_____

When do you have the highest energy level?
_____ Morning _____ Afternoons_____ Evenings
When do you have the lowest energy level?
_____ Morning _____ Afternoons_____ Evenings

Please describe how fatigue or low energy affects your daily activities:

_____

_____

Please describe your mood:

_____

_____

Describe your sleep (in general):

_____

_____

Please describe how sleep deprivation affects your daily activities:

_____

_____

Diet and Nutrition History:
Do you drink coffee/tea? **Yes** or **No** If yes, how much per day? _____
Do you drink soda? **Yes** or **No** If yes, how much per day? _____
Are there any types or groups of foods you crave or eat a lot? _____
Are there any types or groups of foods you dislike or rarely eat? _____
What do you drink on a typical day? _____

Recall of dietary intake: *Please list all foods and drinks you have consumed in the past 24 hours. Include meals, snacks, beverages and condiments.*
Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Is this a typical day? If not, please describe:

_____

_____

What type of oil do you cook with? _____
What type of spreads do you add to your foods? _____
How many cups (8 oz.) of water do you drink on a typical day? _____
How many servings of fruit do you eat on a typical day? _____
(1 serving = 1 small piece, or ½ cup juice, or ½ cup canned or chopped, or ¼ cup dried)
How many servings of vegetables do you eat on a typical day? _____
(1 serving = 1 small piece, or 1 cup fresh leafy greens, or ½ cup raw or cooked, or ¼ cup dried)
Please describe your relationship to food:

_____

_____

Highest weight ever: _____ Desired weight: _____
Please describe your childhood:

_____

_____

How would you rate your own health as a child? **Good** **Fair** **Poor**
Please list any major traumas (emotional, verbal, physical, and sexual) you have experienced:

_____

_____

Is there any other information that you would like to share with us?

_____

_____

Patient Name:_____ DOB: _____

Preventative Testing/Treatment Questionnaire

Flu Vaccination (ALL AGES):

When was your last flu shot? _____

Where did you get your flu shot? _____

If you have not received one this season, would you like one today? **YES** **NO**

Colonoscopy (IF YOU ARE BETWEEN THE AGES 50 - 75 YEARS OLD)

Have you ever had a colonoscopy? **YES** **NO**

If yes, when did you have it and where? _____

If no, would you be interested in having one? **YES** **NO**

Mammogram (IF YOU ARE A WOMAN BETWEEN 50 – 75 YEARS OLD)

When was your last mammogram? _____

Where was your last mammogram? _____

If you haven't had one in the last 2 years, can we schedule one for you? **YES** **NO**

DEXA (IF YOU HAVE HAD ONE IN THE LAST 2 YEARS)

Have you ever had a DEXA? **YES** **NO**

If yes, When/Where was your last DEXA? _____

Pneumonia Vaccine (65 YEARS AND OLDER)

Have you had a pneumonia vaccine? **YES** **NO**

If yes, where/when was your last Pneumonia vaccination? _____

If no, are you interested in receiving one? **YES** **NO**

Account Number:

CAPITAL REGION PHYSICIANS REGISTRATION

PATIENT DEMOGRAPHIC INFORMATION FORM

Today's Date:

PATIENT INFORMATION

Patient Name:	Date of Birth:	Age:
Preferred to be called:	Gender: ☐ Male ☐ Female	
Previous/Maiden Name:	Social Security #:	
Mailing Address:		
If PO Box, Street Address:		
City, State, Zip:		
Email Address: ☐ DO NOT HAVE EMAIL ☐ DO NOT WISH TO SHARE EMAIL ADDRESS		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Partner ☐ Widowed		
Employer: ☐ Unemployed ☐ Retired ☐ Student		

PHONE NUMBERS WHERE WE MAY CONTACT YOU OR LEAVE MESSAGES

Primary Phone #:	Secondary Phone #:	Work Phone #:

PATIENT ETHNICITY	PATIENT RACE			
☐ Hispanic	☐ American Indian or Alaska Native	☐ Native Hawaiian or Other Pacific Islander	☐ White	
☐ Non-Hispanic	☐ Asian	☐ Black or African American	☐ Other Race	

PATIENT PRIMARY LANGUAGE

Language other than English: ☐ Spanish ☐ Hindi ☐ Russian ☐ Other

Interpreter Required: ☐ Yes ☐ No If Yes, Type:

FOR PATIENTS UNDER 18 YEARS OF AGE OR PATIENTS WITH A GUARDIAN/POWER OF ATTORNEY:

RESPONSIBILITY PARTY INFORMATION

Name:	Date of Birth:	
Relationship: ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Power of Attorney	Social Security #:	
Mailing Address:		
City, State, Zip:		
Employer: ☐ Unemployed ☐ Retired ☐ Student		
Primary Phone #:	Secondary Phone #:	Work Phone #:

OTHER PARENT / GUARDIAN INFORMATION

Name:	Date of Birth:	
Relationship: ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian	Social Security #:	
Mailing Address:		
City, State, Zip:		
Employer: ☐ Unemployed ☐ Retired ☐ Student		
Primary Phone #:	Secondary Phone #:	Work Phone #:

PATIENT DEMOGRAPHIC INFORMATION FORM

Patient Name: Date of Birth:

DO YOU HAVE AN ADVANCED DIRECTIVE?

☐ Yes If Yes, does CRMC have a copy of this form on file? ☐ Yes ☐ No

☐ No If No, would you like additional information regarding Advanced Directives? ☐ Yes ☐ No

If Yes, was additional information regarding Advanced Directives provided? ☐ Yes—Staff Initials_____

INDIVIDUALS THAT WE ARE AUTHORIZED TO SPEAK TO ABOUT PATIENT'S CARE

In addition to custodial parents/guardians, *Capital Region Physicians is authorized to speak to the following individuals:*

Contact #1:	Primary Phone #:
Relationship:	Secondary Phone #:
Contact #2:	Primary Phone #:
Relationship:	Secondary Phone #:
Contact #3:	Primary Phone #:
Relationship:	Secondary Phone #:

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR CHILD PATIENT

In addition to custodial parents/guardians, *the following individuals are authorized to accompany this child to receive medical care:*

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

PHARMACY INFORMATION (LOCAL OR MAIL ORDER)

Primary Pharmacy:	Location:
Alternate Pharmacy:	Location:
Mail Order Pharmacy:	Phone/Fax Number:

CIRCLE OF CARE

Please list all Physicians, including other Capital Region Physicians, who are actively participating in or have participated in patient's healthcare during the past year.

PRIMARY CARE PHYSICIAN:

Full Name: _____ City/State: _____

SPECIALISTS:

Full Name: _____ Full Name: _____

City/State: _____ City/State: _____

Specialty: _____ Specialty: _____

Full Name: _____ Full Name: _____

City/State: _____ City/State: _____

Specialty: _____ Specialty: _____

Full Name: _____ Full Name: _____

City/State: _____ City/State: _____

Specialty: _____ Specialty: _____

Account Number: **CAPITAL REGION PHYSICIANS REGISTRATION** Today's Date:

PATIENT DEMOGRAPHIC INFORMATION FORM

Patient Name:	Date of Birth:

PATIENT ACKNOWLEDGEMENTS & AUTHORIZATIONS

With our environment in mind, complete paper copies of the following policies are available upon request for personal use.

* I acknowledge I have been provided with Capital Region Medical Center's Financial Policy, Notice of Privacy Practices, Patient Bill of Rights and information regarding what is done to prevent the spread of infection and what I can do to prevent infections.
* I acknowledge any patient specimens collected at a Capital Region Physician's Clinic will be processed at Capital Region Medical Center and it is my responsibility to inform the staff if I prefer, or if my insurance requires my specimens to go to a different laboratory for processing.
* I understand I am responsible to pay all costs not covered by insurance. If insurance requires a co-pay, it is to be paid at the time of service. I understand and agree to these terms authorizing payment from insurance carriers be made to Capital Region Medical Center and hereby give my permission to release any information necessary to collect from any third party payers. I verify the information on this document and insurance information provided is current and correct.
* I, the undersigned, hereby authorize Capital Region Medical Center physicians to examine and to administer such treatment as is necessary and to perform such procedures as are considered therapeutically or diagnostically necessary.
* I understand I am responsible for notifying Capital Region Physicians when changes occur to the following: Mailing Address, Contact Number(s), Insurance Coverage, Individuals we are authorized to speak to and Individuals authorized to accompany a child.
* I understand Capital Region Medical Center utilizes an electronic prescribing network for prescription medications involving participating pharmacies and other health care providers in order to better avoid medication errors and adverse drug interaction and consent that Capital Region Medical Center may view my medication history.
* I authorize representatives of Capital Region Medical Center and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me by using any telephone number(s) supplied by me and may leave messages with whoever answers the phone or the associated recorder using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Signature of the Adult Patient OR Signature of Responsible Party (for Patients under 18 years of age or with a Guardian/Power of Attorney) **in Agreement to the above Patient Acknowledgements and Authorizations**

Signature Date

Patient could not sign the acknowledgement because of physical impairment. Patient verbally agreed to the above Patient Acknowledgements and Authorizations.

Staff Signature *Date*

Patient Name: _____ DOB: _____

Thank you for taking the time to complete this extensive form. This information will help you and your provider to design the best treatment plan for you.

We look forward to working with you to meet your health and wellness goals.

If you are not able to keep your appointment, please call 48 hours in advance to reschedule. Please be aware that it may be several weeks/months before there is an opening to reschedule the appointment.

□ *Check this box if you would like for your name to be placed on a cancelation list; please complete and return this form within 2 weeks receipt.*