Beyond Functional

Adrian Baume, L.Ac - beyondfunctional.com

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CONFIDENTIAL PATIENT INFORMATION

Please print or write legibly.

Today's Date: _____

Full Name_____

Address_____ Apt_____

City_____ State_____ Zip Code_____

Phone: Home (____)_____ Cell (____)_____

Best number to contact you at? _____What is the best time to reach you?_____

Fax (____)_____ Email:_____

May we subscribe you to our clinic's email newsletter? Yes No

Referred by: [ ]Friend [ ]Website:_____

[ ]Family [ ]Other:_____

Gender: Male Female Pregnant? Yes No # of children:_____

Could you possibly be pregnant now? Yes No

Age_____ Birth date: (Month/Day/Year) _____ /_____ /_____

Height:_____ Weight:_____

Marital Status: Married Single Widowed Divorced

Circle one or more: FT Employment PT Employment FT Student PT Student

Occupation_____ Employer_____

Work Phone (____)_____ May we contact you at the number? YES NO

Person to be notified in case of an emergency:

Name_____

Telephone_____Relationship_____

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Reason for appointment & related health issues/problems?	Date Began?	Had Previously?	Injury Related?

Name of your Primary Care Physician (PCP):_____

PCP Telephone (___)_____ Date of last visit_____

Date of last check up or physical_____

Diagnosis of current health issue(s) if available_____

Are you willing to change your habits in order to improve your health? Yes Maybe No

Are you currently utilizing any other therapies or practitioners for these issues? Yes No

If yes, what practitioner(s)/therapy(ies) _____

MEDICAL HISTORY

Serious illnesses (type, duration, year):

_____

_____

Surgeries (type, year performed):

_____

_____

Known Allergies, Hypersensitivities or Intolerances:

_____

Current Supplements:

_____

_____

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Current Medications (include over the counter):

_____

_____

CONSTITUTIONAL

Hours of sleep per night:_____ If you exercise, what type of exercise?_____

Are you currently or were you previously on a restrictive diet? Yes No

History of treatment for an addiction? Yes No Tobacco / Alcohol / Drugs / Other

Do you have a history of extensive travel to foreign countries? Yes No

If yes, which countries and for how long? _____

FAMILY HISTORY

Please indicate, to the best of your knowledge, whether any of your biological family members have any of the following conditions:

Mother (M) Father (F) Brother (B) Sister (S) Grandparent (G) Your Children (C)

	M	F	B	S	G	C		M	F	B	S	G	C
Allergies	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Hearing Loss	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Alcoholism	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Hypoglycemia	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Bleeding Tendency	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Kidney Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	Nervous/Mental	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

REVIEW OF BODY SYSTEMS

Check any of the boxes below that apply to

1. *Symptoms* that you have experienced in the past 3 months

2. *Diagnoses* you have received during your lifetime

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GENERAL

[ ] Recent weight loss Amount? _____Time period? _____

[ ] Recent weight gain Amount? _____Time period? _____

[ ] Eating Disorder [ ] Body Odor [ ] Tiredness/Weakness

[ ] Sudden energy drop Time of day?_____

[ ] Fever [ ] Strong thirst [ ] Cravings – for:_____

HEMATOLOGIC (BLOOD-RELATED)

[ ] Blood type _____ [ ]Anemia [ ]Bleeding Tendency [ ]Coagulation disorder

[ ]Bruise easily [ ]Cuts heal slowly [ ]Blood clots [ ]Stroke

HEAD, EYE, EAR, NOSE, THROAT

[ ] Disturbances of vision [ ] Red or itchy eyes [ ] Glaucoma [ ] Macular degeneration

[ ] Eyeglasses/contacts [ ] Loss of hearing [ ] Tinnitus/Ringing in ears [ ] Pain in ears

[ ] Disturbances of speech [ ] Trouble swallowing [ ] Sore or dry throat

[ ] Lip or mouth sores [ ] Nosebleeds [ ] Nose or sinus problems

[ ] TMJ pain/problems [ ] Loss of taste or smell [ ] Headache(s) – Type(s)_____

MOUTH

[ ] Bleeding gums [ ] Mercury/amalgam (dark) fillings [ ] Problems with teeth or dentures

[ ] Implants [ ] Other _____

RESPIRATORY (LUNGS)

[ ] Wet Cough [ ] Dry cough [ ] Whooping Cough [ ] Excessive Sneezing [ ] Asthma

[ ] Poor sense of smell [ ] Chest Pain or tightness [ ] Shortness of Breath

[ ] Congestion [ ] Wheezing Rib Pain [ ] Tuberculosis [ ] Emphysema

[ ] Bronchitis [ ] Pneumonia [ ] Pleurisy

GASTROINTESTINAL SYSTEM

[ ] Gripping/cramping [ ] Very Dark Stool [ ] Light colored stool [ ] Rectal pain

[ ] Itching or burning [ ] Celiac Sprue [ ] Crohn's Disease [ ] IBS/IBD

[ ] Diverticulosis/-itis [ ] Hemorrhoids [ ] Ulcerative colitis [ ] Parasite infection

[ ] Lack of appetite [ ] Lactose intolerant [ ] Hiatal hernia [ ] Ulcers

[ ] Indigestion [ ] Candida or other GI [ ] fungus [ ] Abdominal pain

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[ ] Belching [ ] Hepatitis [ ] Cirrhosis

# of bowel movements: per day _____ per week _____

[ ] Other _____

GENITO-URINARY SYSTEM

[ ] Lower Abdominal Pain [ ] Kidney/Renal problem [ ] Renal insufficiency

[ ] Water retention [ ] Abdominal Hernia [ ] Sexually Transmitted Disease [ ] Infertility

[ ] Difficulty with urination (incontinence) [ ] Pain with urination [ ] Interstitial cystitis

[ ] Blood in urine [ ] Dark urine [ ] Urethral discharge [ ] Bladder infection

FEMALE ISSUES

[ ] PMS [ ] Endometriosis [ ] Vaginal Dryness [ ] Miscarriage/Abortion

[ ] Sexual difficulties [ ] Lumps in breasts [ ] Birth Control Pills [ ] Uterine: fibroids/cysts/tumors

[ ] Pregnancy #_____ [ ] Children #_____

MALE ISSUES

[ ] Prostate problems [ ] Sexual difficulties [ ] Testicular pain/swelling

ENDOCRINE (HORMONE) SYSTEM

[ ] Diabetes (Type I or Type II, please circle) [ ] Syndrome X, Metabolic Syndrome

[ ] Hypoglycemia (low blood sugar) [ ] Thyroid problems [ ] Hormone therapy

EMOTIONAL

[ ] Worry [ ] Moodiness [ ] Anxiety [ ] Irritability [ ] Grief

[ ] Problems in Relationships

DERMATOLOGIC (SKIN) AND HAIR

[ ] Oozing skin sores [ ] Psoriasis/Eczema [ ] Rosacea [ ] Loss of hair [ ] Toenail fungus

[ ] Skin fungal infection

IMMUNE SYSTEM

[ ] Seasonal allergies [ ] Chemical sensitivity [ ] Benign tumor [ ] Cancer

[ ] Epstein-Barr Virus (EBV) [ ] HIV / AIDS [ ] Lupus [ ] Thrush [ ] Herpes

[ ] Polio [ ] Mumps [ ] Rubella [ ] Chicken Pox [ ] Malaria [ ] Measles

MUSCULOSKELETAL SYSTEM

[ ] Arthritis – Type(s):_____ [ ] Osteopenia/Osteomalacia/Osteoporosis [ ] Gout

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[ ] Shingles [ ] Fibromyalgia/Chronic Fatigue Syndrome [ ] Joint pain /swelling

[ ] Scoliosis [ ] Flat feet [ ] Pins & needles sensation [ ] Numbness or lack of sensation

[ ] Accident, injury, ortrauma—Which body part(s) was involved? _____

[ ] Vascular (blood vessel) disease [ ] Phlebitis [ ] Aneurysm [ ] Varicose Veins

CENTRAL NERVOUS SYSTEM

[ ] Fainting [ ] Convulsions/Epilepsy [ ] Multiple Sclerosis [ ] Weakness or paralysis

[ ] Loss of feeling or function in body part(s) [ ] Balance difficulties [ ] Dizziness

[ ] Vertigo [ ] Light-headedness [ ] Neuritis (nerve inflammation)

[ ] Parkinson's Disease [ ] Bell's Palsy

CARDIOVASCULAR (HEART) SYSTEM

[ ] High blood pressure [ ] Low blood pressure [ ] High cholesterol

[ ] Chest pain or angina [ ] Edema [ ] History of heart murmur(s)

[ ] Swollen ankles or feet [ ] Heart attack #____ [ ] Stroke/CVA/TIA #___

[ ] Heart disease [ ] Slow heart rate [ ] Fast heart rate [ ] Poor circulation

[ ] Blood clots [ ] Poor blood clotting/coagulation [ ] Sweaty hands or feet

[ ] Anemia [ ] Pacemaker

INFORMED CONSENT FOR PATIENTS

Please read and sign the following in order to completely understand the risks and benefits of our natural healthcare protocols.

I _____, hereby authorize this medical office to perform the following specific procedures as necessary to facilitate my diagnosis and treatments:

- **Medicinal use of nutrition**: therapeutic nutrition and nutritional supplementation.
- **Botanical medicine and supplements**: the use of minerals, vitamins, botanical substances, teas, alcohol-based tinctures, capsules, tablets, cremes, plasters, etc.
- **Acupuncture**: the use of sterile acupuncture needles to gently stimulate the body's healing responses. While extremely rare, there is a risk of bruising or pneumothorax with acupuncture.
- **Lifestyle counseling**: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

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• **Physical Medicine**: manual therapy, therapeutic exercise, and energetic medicine.

I recognize the potential benefits and risks of the procedures as described below:

• **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.

• **Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of natural medication, inconvenience of lifestyle changes.

• **Notice to pregnant women:** all female patients must alert the practitioner if they know or suspect that they are pregnant. Some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by this medical office regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I accept responsibility for the medical charges incurred by myself or the patient that I am guardian over. I agree to pay all bills at the time of service in full, unless other arrangements are made with the Clinic Director. I realize that I play an integral role in my healing process and that in order to produce results I must take responsibility for my health.

By making this appointment and visiting with a provider of this medical office you are making an investment in your health.

Name of patient (please print) _____

Patient's signature _____ Date _____

Guardian or Spouse authorizing care _____ Date _____

CANCELLATION POLICY

As a courtesy to this medical office and other patients, we ask that you **agree to give a minimum of twenty four hours notice to reschedule or cancel any appointment; failure to do so will result in a $25 fee.**

In consideration of other patients' time, we ask that you are on time for your appointments. If you

arrive late, we will do our best to accommodate you, which may necessitate reducing treatment time so that the next patient may begin their treatment on schedule. We thank you for your consideration.
Patient's initials _____ Date _____

Notice of Privacy Rights

Our commitment to your privacy:

We are dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Agreements:

- I understand that record will be kept of the health services provided to me.
- I understand that this record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law.
- I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.
- I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit.
- I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.
- I understand that any questions I have will be answered by my provider to the best of their ability.

Effective Date: January 1, 2015

Patient Acknowledgement

With this signature, I acknowledge my understanding and my agreement to the terms of this notice.
Please print your name: _____
Please sign your name: _____ Date: _____