MEDICAL INTAKE

Today's Date: ____________________

Your Name: ____ Birth Date: ____________________
First Last

Your Address: ______________________________ City: ________________ State:______ Zip: ________

Social Security # ________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Email: ____________________________________ Please send me special offers and newsletters: ☐ Yes ☐ No

Cell phone:__________________________________ Please text me special promotions & offers: ☐ Yes ☐ No

Home Phone: ____________________ Work Phone: ____________________

Spouse's Name ___________________________________ Emergency Contact #: ____________________

Spouse's Known Health Conditions

Children's Names	Age	Kno	Health Conditions
____________________	____	______________________________	
____________________	____	______________________________	
____________________	____	______________________________	
____________________	____	______________________________	

Your Occupation: ________________________________ Employer: ______________________________

Which of the following of our marketing have you seen?

Direct mail	☐ Friend: ____________________
Internet	☐ Magazine, Which One ________________
Radio	☐ Talk:________________________
Sign	☐ Other:________________________

What specifically prompted you to choose us for your healthcare needs?

____

Primary Care Provider: ______________________________ City: ______________ Last Visit: __________

Last check up: ____________ Are you under a doctor's care at the present time? Yes No

If yes, for what?

Name of Doctor: City, S ate:

Insurance Information

Primary Subscriber ______________________________ DOB ________ Relationship to Patient ______________________________

Insurance Co. ____ ID # ____

Is there a Secondary Insurance? ☐ Yes ☐ No Insurance Co. __________________ ID # ______________________________

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay True Health Centers, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "True Health Centers") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to True Health Centers for any and all medical/healthcare services, supplies, tests, treatment and/or medications that **have been or will be** rendered or provided; as well as designating and appointing True Health Centers as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other legal remedies necessary in connection with same.

I hereby assign directly to True Health Centers all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that True Health Centers can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by True Health Centers, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that True Health Centers is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that True Health Centers can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test , treatments, or medications that have been previously provided by True Health Centers. A photocopy, scan, or this document is to be considered as valid and as enforceable as the original.

FINANCIAL POLICY

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard and Patient Payment Solutions. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

Signed this ______ day of ____________________, 20___.

X________________________________ (SEAL)
(patient signature)

X________________________________
(please print patient name)

X________________________________ (SEAL)
(signature of Guardian in applicable)

Chief Complaint

Your reason for this visit: ____

When did your symptoms appear?____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity on a scale from 1 (least) to 10 (severe) ____________

How would you describe your symptoms?____

How often do you have this problem?____

Is this problem: ☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic

What treatment have you already received for your condition? ______________________________

For how long? __________________

Date of Last: Physical Exam__________ X-Ray____________ Lab work____________

Medical History

Females:

Are you currently pregnant? Yes No Pregnancies #:____ Dates: ____________________

Deliveries #_____ Natural delivery or C-section? ________

Menstrual: Age of onset:________ Duration: __________

Are they regular? ▫ Yes ▫ No

Pain associated? ▫ Yes No

Last menstrual period: ____________

For all:

Check all that have applied to you:

Ever broke a bone? ☐ Yes ☐ No If yes, which one(s)? ______________________________

Organ conditions? ☐ Yes ☐ No If yes, wha ? ______________________________

Surgeries? ☐ Yes ☐ No Dates? ______________________________

Do you have any surgical devices in your body?______________________________

Notes:____

____

Family History

☐ Allergies	☐ Mom	☐ Dad	☐ Sibling	☐ Heart Disease	☐ Mom	☐ Dad	☐ Sibling
☐ Autoimmune	☐ Mom	☐ Dad	☐ Sibling	☐ Seizures	☐ Mom	☐ Dad	☐ Sibling
☐ Cancer	☐ Mom	☐ Dad	☐ Sibling	☐ Thyroid disease	☐ Mom	☐ Dad	☐ Sibling
☐ Diabetes	☐ Mom	☐ Dad	☐ Sibling	☐ __________	☐ Mom	☐ Dad	☐ Sibling
☐ Digestive disorder	☐ Mom	☐ Dad	☐ Sibling	☐ __________	☐ Mom	☐ Dad	☐ Sibling

Social Habits

(please select all that apply)

Smoking	Packs :
Alcohol	Drinks week:
Coffee/Tea/Caffeine drinks	Cups/da ·
High Stress level	Reason:

Medications/Supplements

Medications:	*Dosages:*	*What for:*	*Supplements/Vitamins:*	
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___
___	___	___	___	___

Please list any allergies: ___

Check all that have applied to you:

__AIDS/HIV	__Chest pain	__Heart Disease	__Miscarriage	__Rheumatoid Arthritis
__Alcoholism	__Chicken Pox	__Hepatitis	__Mononucleosis	__Rheumatic Fever
__Allergies	__Cholera	__Hernia	__Multiple Sclerosis	__Scarlet Fever
__Anemia	__Constipation	__Herniated Disk	__Mumps	__STD
__Anorexia	__Diabetes	__Herpes	__Nervous Breakdown	__Stroke
__Appendicitis	__Eating Disorder	__High Blood Pressure	__Osteoporosis	__Suicide Attempt
__Arthritis	__Emphysema	__High Cholesterol	__Pacemaker	__Swelling feet
__Asthma	__Epilepsy	__Hormone Replacement	__Parkinson's Disease	__Thyroid Problems
__Bleeding Disorders	__Fractures	__Hypertension	__Pinched Nerve	__Tonsillitis
__BloodTransfusion	__Gallbladder Disorder	__Jaundice	__Pleurisy	__Tuberculosis
__Bronchitis	__Glaucoma	__Kidney Disease	__Pneumonia	__Tumors, Growths
__Bulimia	__Goiter	__Liver Disease	__Polio	__Ulcers
__Cancer	__Gonorrhea	__Malaria	__Prostate Problem	__Whooping Cough
__Cataracts	__Gout	__Measles	__Prosthesis	Other:___
__Chemical Dependency	__Heart Attack	__Migraine	__Psychiatric Care	___

Any other pertinent medical history:

___

___

___

___

___

Date:

Indicate which of the below you have experienced in the last 6 months
1 = Rarely 2 = Occasionally 3 = Frequently 4 = Constant

Eyes/Ears/Nose/Throat/Respiratory:				
Asthma	1	2	3	4
Stuffy Nose	1	2	3	4
Hay Fever	1	2	3	4
Sore Throat	1	2	3	4
Chronic Cough	1	2	3	4
Chest Congestion	1	2	3	4
Frequency Sneezing	1	2	3	4
Itchy/Watery Eyes	1	2	3	4
Drainage	1	2	3	4
Earache/Ear infection	1	2	3	4
Itching	1	2	3	4
Hoarsness	1	2	3	4
Shortness of Breath	1	2	3	4
Wheezing	1	2	3	4
Notes:				

Muscular/Skeletal:				
Muscle Aches	1	2	3	4
Fibromyalgia	1	2	3	4
Arthritis	1	2	3	4
Joint Pain	1	2	3	4
Low Back Pain	1	2	3	4
Neck Pain	1	2	3	4
Wrist/Hand Pain	1	2	3	4
Elbow Pain	1	2	3	4
Shoulder Pain	1	2	3	4
Hip Pain	1	2	3	4
Knee Pain	1	2	3	4
Ankle/Foot Pain	1	2	3	4
Pain Between Shoulders	1	2	3	4
Notes:				

Cardiovascular				
Shortness of Breath w/activity	1	2	3	4
Difficulty Breathing when Lying down	1	2	3	4

Gastrointestinal:				
Constipation	1	2	3	4
Diarrhea	1	2	3	4
Reflux or Heartburn	1	2	3	4
Bloating	1	2	3	4
Gas	1	2	3	4
Nausea or Vomiting	1	2	3	4
Crohn's Disease	1	2	3	4
Stomach Pains	1	2	3	4
Cramping	1	2	3	4
Notes:				

Urinary:				
Frequency	1	2	3	4
Urgency	1	2	3	4
Burning or Pain	1	2	3	4
Blood in Urine	1	2	3	4
Incontinence	1	2	3	4
Notes:				

Skin:				
Rashes	1	2	3	4
Eczema	1	2	3	4
Itching	1	2	3	4
Dryness	1	2	3	4
Loss of Hair	1	2	3	4
Excessive Sweating	1	2	3	4
Notes:				

Neurological				
Headaches	1	2	3	4
Migraines	1	2	3	4
Dizziness	1	2	3	4
Numbness	1	2	3	4
Tingling	1	2	3	4
Notes:				

Endocrine/Hormones:				
Weight Loss or Gain	1	2	3	4
Inability to Lose Weight	1	2	3	4
Hypo/Hyper Thyroid	1	2	3	4
Change in Appetite	1	2	3	4
Fatigue or Drowsiness	1	2	3	4
Poor Sleep	1	2	3	4
Decreased Endurance	1	2	3	4
Feel "Burned Out"	1	2	3	4
Hot Flashes	1	2	3	4
Night Sweats	1	2	3	4
Notes:				

Reproductive:				
Pain During Sex	1	2	3	4
Low Sex Drive	1	2	3	4
Erectile Dysfunction	1	2	3	4
Notes:				

Mental/Emotional:				
Anxiety	1	2	3	4
Stress	1	2	3	4
Depression	1	2	3	4
Poor Concentration	1	2	3	4
Foggy Thinking	1	2	3	4
Forgetfullness	1	2	3	4
Mood Swings, Irritability or Grumpiness	1	2	3	4
Notes:				

Other:				
Fever or Chills	1	2	3	4
Weakness	1	2	3	4
Hyperactivity	1	2	3	4
Insomnia	1	2	3	4
Autoimmune	1	2	3	4
Allergies	1	2	3	4

Notes:____

ALLERGY HISTORY

Patient Name ____________________________ Date. _______________________

Patient Number __________________________ Age _______ M/F

Branson Allergy Symptom Evaluation™ (BASE)

COMPLAINTS:

Please circle the appropriate number 0 to 3 according to severity:

0 = absent (no symptoms evident)
1 = mild (symptoms present, but minimal awareness),
2 = moderate (tolerable)
3 = severe

Symptom					Symptom				
Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Itching ears	0	1	2	3
Watery eyes	0	1	2	3	Sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Sensitivity to pet hair	0	1	2	3
Cough	0	1	2	3	Itchy throat	0	1	2	3
Wheezing	0	1	2	3	Sinus pressure	0	1	2	3
Difficulty breathing	0	1	2	3	Sinus pain	0	1	2	3

Other symptoms causing you problems?

____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never 1 = occasionally (several times a month or less) 2 = frequently (several times a week)
3 = daily

Medication					Medication				
Antihistamines	0	1	2	3	Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids	0	1	2	3	Asthma medication (Inhaler, Singulair, Advair)	0	1	2	3
Eye drops	0	1	2	3	Other allergy-related medications ____________________				

Does any medication give you complete relief of symptoms? ____________________

GENERAL ALLERGY HISTORY:

How many months of the year do you have allergies? ______ How many years? ________
In what season are they worse (check all that apply): O Spring O Summer O Fall O Winter
Have you been allergy tested before? O Yes O No
If yes, which type: O Skin prick/Puncture O Blood draw
Have you previously received allergy shots? __________Allergy drops?________ If yes, when? __________
Do you smoke or use tobacco products? _____________
List any animals you have in or around the home ______________________________
Who else in your family has allergies? ____

PROVIDER ONLY
RAW SCORE: _________ /25 **0-25 = MILD** **26-50=SIGNIFICANT**
SCORE: __________ (Multiply raw score by 4) **51-100 = SEVERE** **100+= VERY SEVERE**

PRIVACY POLICY

Our Privacy Obligations.

We maintain the privacy of medical and health information of any individual for whom we provide services ("Protected Health Information" or "PHI") and endeavor to comply with all relevant state, national, and international laws and regulations including the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996. We abide by the terms of this Notice, as amended from time to time.

1. **Use and Disclosures Requiring Your Written Authorization/Use or Disclosure of PHI with Your Authorization**
    a. We require your authorization, given upon an executed release form, to use or disclose PHI. After we receive your authorization, we will use and disclose PHI to provide our services to you. This authorization will allow us to collect information from hospitals and doctors' offices you identify in order to provide you our services. We may also disclose PHI to other medical institutions or medical professionals who are involved in the delivery of our services to you.
    b. We will not disclose PHI to a family member, relative, friend, or any other person unless they are specifically identified by you on your authorization as appropriate to receive PHI. If you object to such uses or disclosures, please notify the Office Manager.
    c. We may disclose PHI to the physician(s) or medical institutions you identify on your authorization when such PHI is appropriate for them to continue your treatment or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for healthcare fraud and abuse detection or compliance.
    d. <u>HIV-related Information Limitation</u>.
    We require a separate, specific and independent release to use or disclose Confidential HIV-related information, except, in certain limited circumstances, to public health or other government officials or persons with whom you have had sexual contact or shared needles or syringes (in each case as required by law), or to persons specified in a special court order, or to certain persons with whom you have had sexual contact or shared needles or syringes.
    e. <u>Payment</u>.
    Unless you have specifically agreed in advance, we will never use or disclose your PHI to obtain payment from the entity from whom we are paid. We may share de-identified information (information which does not include your name, address, social security number or other way to identify who you are) with such payers.
    f. <u>Marketing Communications</u>.
    We will never use your PHI for any marketing materials without first receiving a written authorization, a testimonial release. We will never require your

execution of a testimonial release before you may receive our service. We will also never use your PHI for mass marketing purposes.

2. **Permissible Uses and Disclosures Without Your Written Authorization.**
   We are not required to receive an authorization from you for the following uses and disclosures:
   a. Operations.
      We may use and disclose PHI for our service operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the services that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our personnel and consulting medical institutions and medical professionals. We may disclose PHI to our management in order to resolve any complaints you may have and ensure that you receive the highest quality services.
   b. Public Health Activities
      We may disclose PHI for the following public health activities to report:
      - information to public health authorities for the purpose of preventing or controlling disease, injury or disability
      - information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government programs
      - child abuse, neglect or domestic violence, to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence
      - information about products and services under the jurisdiction of the U.S. Food and Drug Administration
      - to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
      - to prevent or lessen a serious and imminent threat to a person's or the public's health or safety
      - to organizations that facilitate organ, eye or tissue procurement, banking or transplantation
      - for research purposes if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure
      - Information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance

3. **Governmental Proceedings**
   We may disclose PHI for the following governmental proceedings to report:
   a. in the course of a judicial or administrative proceeding in response to a legal order or other lawful process
   b. to the police or other law enforcement officials as required or permitted or permitted by law or in compliance with a court order or a grand jury or administrative subpoena
   c. to a coroner or medical examiner as authorized by law
   d. to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law
   e. as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs
   f. when required to do so by any other law not already referred to in the preceding categories

4. **Your Individual Rights** (or Further Information; Complaints)

   If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to PHI, you may contact our Privacy Officer. You may reach our Privacy Officer at____. You may also file written complaints with the relevant local, state, national, or international privacy agency. We will not retaliate against you if you file a complaint with us or any governmental agency.

5. **Right to Request Additional Restrictions**
   You may request restrictions on our use and disclosure of PHI
   a. For treatment, payment and health care operations
   b. To individuals involved with our delivery of services to you, or
   c. To notify or assist in the notification of such individuals regarding your location and general condition

All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

I have read and understand the contents of this agreement. In addition, I was offered the opportunity to ask questions about this agreement and, if I had questions, they were answered to my satisfaction.

____________________ ________________________ __________________

Patient Name (Print) Patient Signature Date

True Health Medical
3303 E. Baseline Rd.
Gilbert, AZ 85234
480-964-5234

Consent for Medical Treatment

Patient Name: ____

I hereby voluntarily consent to the rendering of such care, including diagnostic procedures, chiropractic and medical treatment, by authorized members of True Health Medical staff or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment.

We/I hereby give my consent to True Health Medical to provide medical care and treatment necessary to preserve my health.

- I understand that the physician and medical personnel will rely on statements about my medical history and other corresponding records pertaining to my condition to determine whether to perform the above procedure which has been explained to me and is recommended as a course of treatment for my condition.

- I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES have been made to me concerning the results of this procedure.

- I understand that during the course of the procedure described above, it may be necessary to perform other procedures which are unforeseen, or not known to be needed at the time of this signed consent/authorize the physician herein to make the decision concerning such procedure, if additional procedures are deemed necessary or appropriate

- I also consent to the diagnostic studies, test, local anesthesia and/or general anesthesia, x-ray examinations and any other course of treatment related to the diagnosis or procedure explained herein. Too, I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND/OR THE FORM HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

I voluntarily consent to allow any Physician or Nurse Practitioner designated True Health Medical and all medical personnel under the provider's direct supervision to be involved in performing such procedures described or otherwise referred to herein.

Print Patient's Name	Signature of Patient	Date

Print Doctor's Name	Signature of Doctor	Date