Intake **Dr. Michael Hollis ND**

Personal Data

Name: _____
First *Last*

Address: _____
Street *City, State* *Zip Code*

Phone: _____ **Preferred:** ☐Home ☐Work ☐Cell
Home *Work* *Cell*

Date of Birth: _____ Age: _____ **Years of Education/Highest Degree:** _____
Month/Day/Year

Current Height: _____ **Current Weight:** _____ **Ideal Weight:** _____

Occupation: _____ **Employer:** _____

Marital Status: _____ **Spouse/Partner's Name:** _____

Email: _____

****** Please list any allergies and/or reactions to medication:*** _____

_____

Emergency Contact: _____
Name *Contact #* *Relationship to patient*

Whom may we thank for your referral/ how did you hear about us? _____

Primary Care Physician

Name: _____ Phone: _____

Address: _____
Street *City, State* *Zip Code*

Communication Preferences

As your cell phone and email are not considered "secure" communication devices:

- Is it acceptable for us to contact you with medical information via email: □ Yes □ No
- Is it acceptable for us to leave messages on a voicemail/answering machine for you? □ Yes □No

Patient Initials: _____

Medical History

How would you rate your health? □ Excellent □ Good □ Fair □ Poor

Present health concerns: _____

_____

<u>Personal Medical History</u>:

***** Please indicate whether you have had any of the following medical problems (with dates):***

□ Heart Disease _____ □ Alcoholism: _____
□ Heart Attack _____ □ Bleeding/Clotting Disorder _____
□ Blood Transfusion _____ □ High Cholesterol _____
□ High Blood Pressure _____ □ Cancer/Malignancy _____
□ Diabetes Type 1 _____ □ Diabetes Type 2 _____
□ Thyroid Problems _____ □ Depression _____
□ Other (please specify): _____

<u>Surgical History:</u>

Please list all prior operations (with dates): _____

_____

_____

Medications

***Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.:*

Medication	Dosage (i.e. mg/pill)	Frequency	Date Started

Health Maintenance

***When was your most recent health maintenance screening tests?*

Test	Date Performed	Results
Cholesterol screening		
Mammogram		
Pap smear		
Prostate cancer screen/PSA		
Stool test (for blood)		
Sigmoidoscopy		
Other		

Food Allergies/Intolerances

*** Please list any food allergies and/or intolerances:*

Food	Allergy (✔)	Intolerance (✔)	Reaction

Family History

***Please indicate the current status of your immediate family members:*

Relation	Alive (✔)	Deceased (✔)	Age (present or at death)	Cause of Death
Mother				
Father				
Sibling				
Sibling				
Child				
Child				
Other				

***Please check (✔) family members who have had any of the following conditions:*

`	Mom	Dad	Sibling	Sibling	Child	Child
Alcoholism						
Anemia						
Arthritis						
Asthma						
Autoimmune Disorder						
Bleeding Disorder						
Breast Cancer						
Colon Cancer						
Melanoma						
Ovarian Cancer						
Prostate Cancer						
Heart Attack (Coronary Artery Disease)						
Birth Defects						
Depression						
Diabetes, Type 1 (childhood onset)						
Diabetes, Type 2 (adult onset)						
Eczema						
Food Intolerance/Sensitivities						
Hay Fever/Environmental Allergies						
Hearing Problems						
High Cholesterol						
High Blood Pressure						
Kidney Disease						
Osteoporosis						
Epilepsy (seizure disorder)						
Stroke						
Substance Abuse						
Thyroid Disorders						
Smoking						
Other						

Social History

Tobacco Use:

Do you use tobacco? ☐ Yes ☐ No Type: ☐ Cigarettes ☐ Pipe ☐ Cigar ☐Chew

Cigarettes: ☐ Never ☐ Yes Frequency: _____ Quit Day: _____

Packs/day: _____ # of Years: _____ Interested in quitting? ☐ Yes ☐ No

_____

Alcohol & Drug Use:

Do you consume alcohol? ☐ No ☐ Yes # of drinks per week _____

Is alcohol use a concern for you or others? ☐ No ☐Yes

Do you use any recreational drugs? ☐ No ☐ Yes

Sexual Activity:

Are you sexually active? ☐No ☐ Yes ☐ Not currently

Birth Control Method: _____

_____

Nutrition & Exercise:

Caffeine intake: ☐ No ☐ Yes ☐ Coffee/tea _____ cups/day ☐ Soda _____ cups/day ☐ Chocolate ____oz./day

Are you satisfied with your weight? ☐ No ☐ Yes

How do you rate your diet? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently following any specific diet? ☐ No ☐ Yes

How often do you eat out? _____ # of times per week

Where do you typically eat out? _____

Where do you typically grocery shop? _____

Do you take supplements? (listed on medication sheet) ☐ No ☐ Yes

Do you exercise regularly? ☐ No ☐ Yes What kind of exercise? _____

Minutes per workout: _____ How often? _____

Specialty History

Female Gynecological History:

Of pregnancies _____ # of deliveries _____ # of abortions _____ # of miscarriages _____

1st day/date of most recent period _____ Age at 1st period _____

Frequency of periods _____ Length of each period _____

Do you have any concerns about your periods? ☐ No ☐ Yes Please explain _____

Do you have any concerns about menopause? ☐ No ☐ Yes Please explain _____

Review of Systems

Please check (✔) any current problems you have on the list below:

Constitutional:
☐ Fever/chills/sweats
☐Unexplained weight loss/gain
☐ Change in energy/weakness
☐ Excessive thirst or urination

Eyes:
☐ Change in vision

Ears/nose/throat/mouth:
☐ Difficulty hearing/ringing in ears
☐ Problems with teeth/gums
☐ Hay fever/allergies

Chest:
☐ Breast lump
☐ Nipple discharge

Musculoskeletal:
☐ Muscle pain
☐ Joint pain

Respiratory:
☐ Cough/wheeze
☐ Difficulty breathing

Gastrointestinal:
☐ Abdominal pain
☐ Blood in bowel movement
☐ Nausea/vomiting/diarrhea

Genitourinary:
☐ Nighttime urination
☐ Leaking urine
☐ Unusual vaginal bleeding

Cardiovascular:
☐Chest pain/discomfort
☐ Palpitations
☐ Edema/swelling

Skin:
☐ Rash
☐ Mole change

Neurological:
☐ Headaches
☐ Dizziness/lightheadedness
☐ Numbness/tingling
☐ Memory loss
☐ Loss of coordination

Psychiatric:
☐ Anxiety/stress
☐ Problems sleeping
☐ Depression
☐ Mood swings

Blood/lymphatic:
☐ Unexplained lumps
☐ Easy bruising/bleeding

Sexuality:
☐ Problem w/ sexual function
☐ Decrease in sex drive

HIPPA

SECTION A: PATIENT GIVING CONSENT
Purpose of Consent: By signing this form, you will give consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice of Privacy provides a description of our treatments, payment activities and healthcare operations, of the disclosures we may make your protected health information, and of other important matters about your protected health information.

A copy of our Notice of Privacy is available upon request. We encourage you to read it carefully and completely before signing this consent form.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, whish will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting us in writing at: **Renew INM, 1640 Newport Blvd. #360, Costa Mesa, CA 92627.**

Right to Revoke: You have the right to revoke this Consent at any time by giving written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES
I, (print name) _____ have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____
You are entitled to a copy of this Consent after you sign it.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Printer Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I revoke my Consent.

Signature: _____ Date: _____

GENERAL INFORMED CONSENT

I seek the medical and health care services of LINK Medical Center's employees and staff. I understand that this is not a hospital-based office and that I must maintain a relationship with a primary care physician and/or an internist or both. LINK Medical Center's staff is willing to work with any physician that you have previously seen or are currently working with.

I understand that this medical practice uses some diagnostic and treatment methods that are variously known as, but not limited to, Naturopathic, environmental, complementary, alternative, integrative, or nutritionally orientated. I agree to treatment using, but not limited to, nutrition, lifestyle, homeopathy, manipulation, herbs, chelation, acupuncture, pharmaceuticals, prolotherapy, and intravenous and other injection therapies. Some of these methods, as most medical procedures, carry a level of risk. I am fully aware of the risks and choose to continue with the treatments even though FDA or conventional medical practitioners may not accept the treatments or conform to common standards of practice in the United States. I understand that no claims, representation or guarantees are being made and that undergoing treatment with LINK Medical Center may not help my health conditions or medical problems.

I understand that LINK Medical Center makes recommendations for supplements and other products available in office, and on websites, and that these are sold on a for profit basis. I am not obligated to purchase these products from this office, and I may purchase these products from any source that I may choose. I understand if I choose to purchase oral, injectable or other forms of supplements from LINK Medical Center all sales are final and they may not be returned for exchange or refund.

I understand that under California proposition 65 there may be some toxins or chemicals I may be exposed to either in the LINK Medical Center environment, supplements purchased or therapies/treatments provided which California has deemed potentially harmful to my family or me. I understand I may view the full Proposition 65 list by visiting http://oehha.ca.gov/prop65/prop65_list/Newlist.HTML and agree I will not hold LINK Medical Center responsible for any claim or damages as a result of any exposure.

I understand that cancellations, without sufficient warning, and "no-shows" play havoc with office scheduling and paperwork. Therefore, I agree to give at least a 24-hour notice if I must cancel and appointment. In the event that I do not give a 24-hour notice, I give LINK Medical Center the right to charge me a $50.00 fee.

I understand that most health insurance plans today have clauses that limit coverage to "usual and customary services." Many of the treatments used in integrative and alternative medicine are not recognized by consensus mainstream medicine; therefore we cannot guarantee the amount or availability of coverage for our service and treatment under your health insurance policy. I understand that I am responsible for payment of the invoice at the time of service, without regard to insurance coverage. I also understand that, upon my request, the cost of all procedures and services will be told to me before they are performed.

I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that, by signing this consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

I have read, understand and agree, to the foregoing. I agree that if I have any claim with respect to the services and treatment given to me by LINK Medical Center, its employees and/or staff that they shall be judged by the standards and principles of Naturopathic, environmental, complementary, alternative, and integrative medicine. I understand that I have the right to review this consent with a lawyer if I choose. I have executed this consent freely and willingly and understand its provisions. I recognize that LINK Medical Center will rely upon execution of this document in accepting me as a client.

_____	_____	_____
Print Patient Name	Patient or Guardian Signature	Date

INJECTION THERAPY INFORMED CONSENT

I herby permit LINK Medical Center, Dr. Michael Hollis, or his/her associates and assistants as may be selected and supervised by him/her, to perform the following medical treatment, procedure or operation (hereafter the "procedure"):

- Intravenous (IV) Therapy
- Intramuscular (IM) Therapy
- Subcutaneous (SC) Therapy
- Prolotherapy
- Trigger Point Therapy
- Phlebotomy Procedures

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure.

If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment that is necessary.

Printed Name: _____ **Date of Birth:** _____

_____

Signature of Patient ***Date***

I, _____ am a facility employee who is not the patient's physician or authorized health care provider named above and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____

Signature of Named Witness ***Date***