Bend Regenerative Medicine

REGISTRATION INFORMATION

Patient Information

First Name:	Last Name:	Date:
Address:	City:	State:	Zip Code:
Home Phone: ☐ yes, we can a leave message	Cell Phone: ☐ yes, we can leave a message	Work Phone: ☐ yes, we can leave a message
Email Address:	Employer:	Occupation:
Date of Birth:	SS#:	Age:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single ☐ Other
Emergency Contact:	Relationship to you:	Emergency Contact Phone:	Emergency Alternate Phone:
How were you referred to our clinic? ☐ Family / Friend ☐ Previous CIM Patient er: _____ ☐ Physician ☐ Web Site ☐ nsurance Company ☐	Whom May we thank for referring you:		

Insurance Information

Insurance Company:	Subscriber Name:	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Subscriber Date of Birth:
Subscriber Employer:	Policy / ID #:	Group #:	Phone:

Center for Integrative Medicine

E. Payson Flattery ND, DC, PC Mary Ellen Coulter, MD CCH Keith Bell, PA-C, CMT Debrah Harding, ND, FABNO Sarah A. Conneely RN, MSN, ANP

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Secondary Insurance Information

Insurance Company:	Subscriber Name:	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Subscriber Date of Birth:
Subscriber Employer:	Policy / ID #:	Group #:	Phone:

Accident Information

Is your current condition due to an accident? ☐ Yes ☐ No Date of accident: _____ / _____ / _____	Type of accident: ☐ Auto ☐ Work ☐ Other: _____	To whom have you made a report of your accident? ☐ Auto Insurance ☐ Worker Comp ☐ Employer ☐ Other: _____
Case Manager:	Phone:	Referring Physician:

Payment Method

☐ Cash / Check	☐ Credit Card	☐ Health Insurance	☐ Workers Compensation	☐ Other: _____

Acknowledgement

I acknowledge that the information stated above is true. I authorize payment of all insurance benefits, if any, for the health care services or goods rendered to be made directly to the Center for Integrative Medicine. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The Center for Integrative Medicine may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

_____
Printed Name of Patient **Date**

_____

_____
Signature of Patient / Guardian / Personal Representative **Relationship to patient**

PRESENT HEALTH INFORMATION

Reason for your visit today:	Date of last physical exam:
When did symptoms appear?	Is this condition getting: ☐ Worse ☐ Same ☐ Better

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Does this condition interfere with:

☐ Work ☐ Daily Routine
☐ Energy ☐ Digestion ☐ Recreation ☐ Sleep ☐ Emotional State

How would you best describe your pain:

☐ Sharp ☐ Dull ☐ Throb
☐ Numb ☐ Shooting ☐ Cramp
☐ Ache ☐ Burn ☐ Tingle ☐ Stiff ☐ Swelling ☐ Other

Activities or movements that are painful / difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Please circle the number that best rates the severity of your condition:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Are you currently receiving treatment for this condition? ☐ Yes ☐ No

☐ Medications ☐ Physical Therapy ☐ Chiropractic
☐ Surgery Other: _____

Doctor / Practitioner: _____

Have you previously received treatment for this condition? ☐ Yes ☐ No

☐ Medications ☐ Physical Therapy ☐ Chiropractic
☐ Surgery Other: _____

Doctor / Practitioner: _____

What type of treatment has provided the most relief?

☐ Medications ☐ Physical Therapy ☐ Chiropractic ☐ Surgery Other: _____

Doctor / Practitioner: _____

What are your goals and expectations for treatment of this condition?

Surgeries / Hospitalizations

Date:	Procedure:

Date:	Procedure:

Medications / Supplements - Please list all medications and supplements that you are currently taking and your reason for taking them:

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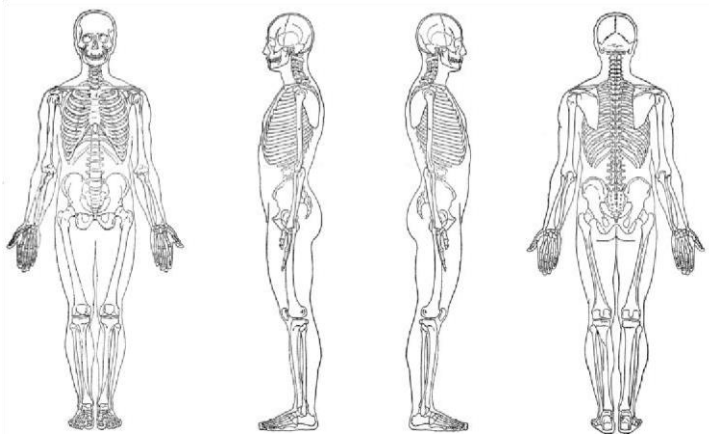
Allergies Please list all food, drug, environmental or chemical allergies or hypersensitivities that you are aware of:

Mark an X where you have symptoms



Habits

Alcohol Consumption Drinks / Week: _____
Coffee / Caffeine Consumption Cups / Day:_____
Tobacco Use Times / Day: _____

Exercise None Moderate Daily
Stress Level Low Medium High

Family History Circle if your blood relatives had any of the following:

Disease:	**Relationship to you**:
Arthritis / Gout	_____
Asthma / Hay Fever	_____
Cancer	_____
Diabetes	_____
Heart Disease / Stroke	_____
High Blood Pressure	_____
Thyroid Disease	_____
Other	_____

Printed Name of Patient:	Date:

HEALTH HISTORY

System Review - Please check all that apply

Do you have or have you had any of the following conditions:

☐ AIDS/HIV ☐ Bleeding ☐ Disorder Epilepsy Herpes
☐ High Blood Pressure: ☐ Dependency ☐ Cancer ☐ Heart Disease Pacemaker Last BP Reading: _____ / _____
Alcohol / Chemical
Blood Clots Diabetes Hepatitis A/B/C Stroke Date Taken: _____

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Mental / Emotional

- ☐ Anxiety
- ☐ Depression
- ☐ Mental Tension / Stress
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Poor Concentration
- ☐ Poor Memory
- ☐ Other:

_____

Energy / Immunity

- ☐ Chronic Infections
- ☐ Fatigue
- ☐ Frequent Common Cold
- ☐ Slow Wound Healing
- ☐ Other:

_____

Sleep

Number of hours per night:

_____

- ☐ Difficulty falling asleep
- ☐ Disturbing Dreams
- ☐ Insomnia
- ☐ Not rested upon waking
- ☐ Restless Sleep:
- ☐ wake _____ x / night
- ☐ Other:

_____

Musculoskeletal

- ☐ Arthritis / Joint Pain
- ☐ Back Pain - Upper / Mid / Low
- ☐ Limb Pain - Upper / Lower
- ☐ Muscle Weakness
- ☐ Muscle Spasms / Cramps
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Stiffness
- ☐ Other:

_____

Date of Last DEXA:

_____

Head

- ☐ Headaches
- ☐ Head Injury
- ☐ Memory Loss
- ☐ Migraine Headaches
- ☐ Other:

_____

Eyes

- ☐ Blurry Vision
- ☐ Dryness / Tearing
- ☐ Eye Pain / Strain
- ☐ Floaters / Spots
- ☐ Impaired Vision
- ☐ Twitching
- ☐ Other:

_____

Ears

- ☐ Dizziness / Vertigo
- ☐ Earache / Pain
- ☐ Ear Ringing / Tinnitus
- ☐ Impaired Hearing
- ☐ Other:

_____

Nose / Sinus

- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Sinus Congestion / Infection
- ☐ Nose Bleeds
- ☐ Other:

_____

Mouth / Throat

- ☐ Canker Sores
- ☐ Dry Mouth
- ☐ Halitosis
- ☐ Sore Throats / Hoarseness
- ☐ Teeth / Gum Disease
- ☐ TMJ / Jaw Pain / Grinding
- ☐ Other:

_____

Endocrine

- ☐ Excessive Thirst / Hunger
- ☐ Excessive Sweating
- ☐ Feeling Hot or Cold
- ☐ Hyper / Hypo Thyroid

Respiratory

- ☐ Asthma / Wheezing
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Sputum
- ☐ Other:

_____

Cardiovascular

- ☐ Chest Pain / Tightness
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Palpitations / Fluttering
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ Other:

_____

Neurological

- ☐ Loss of Balance
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizure / Epilepsy
- ☐ Tremor
- ☐ Vertigo / Dizziness
- ☐ Other:

_____

Gastrointestinal

Bowel Movement how often? _____ x / every _____ days

Urinary

- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Frequent Nighttime Urination:
- ☐ x / per / night

_____

- ☐ Frequent Urination
- ☐ Frequent UTI
- ☐ Lack of Bladder Control
- ☐ Kidney Disease / Stones
- ☐ Painful Urination
- ☐ Other:

_____

Male Reproduction

- ☐ Hernia
- ☐ Impotence
- ☐ Penile Discharge / Sores
- ☐ Prostate Disease
- ☐ Testicular Pain / Swelling
- ☐ Other:

_____

Female Reproduction

- ☐ I am pregnant / Due: _____
- ☐ I am trying to get pregnant

Number of Pregnancies:

_____

Number of Births:

_____

Date of Last Menstrual Period:

_____

Date of Last Pap Smear:

_____

Date of Last Mammogram:

_____

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☐
☐
☐
☐
☐
☐

Skin

Acne
Bruise Easily
Dryness / Itching
Eczema / Hives / Rashes
Lumps
Other:

_____

Hypoglycemia
Other:

_____

☐ Abdominal Pain
☐ Acid Reflux / Heartburn
☐ Blood / Mucus in Stool
☐ Changes in Appetite
☐ Constipation
☐ Diarrhea
☐ Gall Bladder Disease / Stones
☐ Gas / Bloating
☐ Hemorrhoids
☐ Liver Disease
☐ Loose Stool

Nausea / Vomiting
Ulcers
Undigested Food in Stool
Other:

_____

☐ Abnormal Discharge
☐ Breast Tenderness / Lumps
☐ Clotting
☐ Dryness or Itching
☐ Heavy Flow
☐ Hot Flashes / Night Sweats
☐ Irregular Menstruation
☐ Ovarian Cysts
☐ Pain During Intercourse

Painful Menses
PMS
Spotting
Other:

_____

Do you have adequate physical and emotional support at home to meet the challenges of your present condition? ☐ Yes ☐ No

Printed Name of Patient:	Date:

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Consent to Treatment

This is to acknowledge that I have been informed and understand that:

- Any treatment or advice provided to me as a patient of below named practitioners is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from any other health care provider.
  - E. Payson Flattery ND, DC,
  - PC ○ Mary Ellen Coulter MD,
  - CCH ○ Keith Bell, PA-C,CMT ○
  - Debrah Harding, ND, FABNO ○
  - Sarah A. Conneely RN, MSN,
  - ANP
- I am at liberty to seek or continue medical care from a medical doctor or other health care provider.
- No physician, employee, agent or anyone under the direction or control of the clinic is recommending that I refrain from seeking or following the advice of another licensed health care provider.
- The treatment and therapies provided or recommended by this clinic may be different from those usually offered by another licensed health care provider.
- I understand known risks of my choices and was given the opportunity to ask questions.

Financial Policies

As a courtesy to you, the Center for Integrative Medicine will submit charges for medical treatment to your insurance company. However, you are financially responsible for all charges incurred at this office, including your insurance deductible, copayment, fees for services, costs of supplements and remedies, cost of laboratory tests, and any portions of charges or other fees that are not covered by your insurance plan. The Center for Integrative Medicine requires co-pays and/or payment for treatment to be paid at the time of service. Payment may be made in the form of cash, check, or credit card.

Cancellation Policy

If you need to cancel or reschedule an appointment, the Center for Integrative Medicine requires that you do so at least twenty-four hours before your scheduled appointment time. Failure to do so may result in a charge of $50.00 billed to your account.

I hereby authorize the Center for Integrative Medicine's Consent to Treatment.

Printed Name of Patient:	Date:
Signature of Patient / Guardian / Personal Representative:	Relationship to patient:

***Parent / Guardian MUST sign if patient is under 18 years of age**

Please note:
The information provided on this form is confidential.

It is very important the information given is complete and accurate to properly assist you in your healing process. Please take a moment to review your form and make sure it is complete.

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