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PATIENT DEMOGRAPHIC INFORMATION

Full Legal Name:		DOB:	
Previous/Maiden Name:		SSN:	
Race: ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Alaska Native ☐ Caucasian ☐ Mediterranean ☐ Other:		Gender M F	Marital Status Single Married
Phone Number:	Email:	Preferred Pharmacy:	
Home Address:			
Emergency Contact Name:	Emergency Contact Phone:	Emergency Contact Relationship:	

IF PATIENT HAS A LEGAL GUARDIAN or HEALTHCARE PROXY PLEASE COMPLETE THE FOLLOWING:

Legal Guardian Name:		DOB:
Relationship to Patient:	Phone:	
Address:		Primary Contact for Billing: Yes No

Insurance Information:

Billing Preference: Insurance Medicaid (Includes Denali KidCare) Self Pay		Primary Insurance:
Name of Policy Holder:		Secondary Insurance:
Relationship to Patient:	DOB:	Insurance ID #:

Private Health Information

As our client we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take precautions to protect your private health information. When it is appropriate and necessary, we will provide the minimum information to only those we feel are in need of your health care information for treatment, payment or health care operations. I acknowledge that I have received, or had the opportunity to receive, a full copy of our **Notice of Private Policies (NoP).** I understand that I can obtain an additional copy of these rights from this office or my portal any time. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule gives individuals the right to request a restriction on uses of Private Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's home, work, or fax, number. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure for PHI to the minimum necessary to accomplish the intended purpose.

These provisions do not apply to uses made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. By supplying my phone number, email address, and any other personal contact information, I authorize my healthcare provider to disclose my PHI.

Signature:	Date:

I authorize my healthcare provider to communicate my PHI in the following manner:

Provider may mail my information to my mailing address:	Yes	No
Provider may leave a voicemail on my cell phone:	Yes	No
Provider may send information to email provided on page one:	Yes	No

Provider may release information to the following individuals

Name	DOB	Relationship	Phone Number

Consent for Treatment And Financial Agreement

I authorize the collective health care providers at Karis Integrative Medicine, LLC to render mutually agreed upon services as necessary for my care and/or my family.
I understand that I am responsible for all fees regardless of insurance. I understand that fees will be generated for all services rendered if paying with insurance; I am responsible for furnishing the insurance information correctly to the office prior to treatment unless other arrangements have been made in advance. I hereby authorize Karis Integrative Medicine, LLC to furnish information to insurance carriers concerning my illness/injury and treatment and hereby assign all payments for medical services rendered to myself and my dependents. I understand that Karis Integrative Medicine, LLC uses an outside billing service and I may be contacted by them for payment or additional billing related information.

Signature:	Date:

Health Inventory

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Please list any other providers or hospitals you visit or have visited in the last 7 years. This will help coordinate your care.

Office Name	Provider Name	Reason for Appointment	Treatment

Allergies

Allergy	Reaction

Medications and Supplements

Name	Dose	Frequency

I consent to have my medication history imported: Yes No

Immunizations and Vaccinations

Type	Date	Adverse Reactions
Covid 19 mRNA Shot		
HPV		
Flu		
Childhood Immunizations		

Have you felt down, depressed or hopeless in the last 8 weeks?	Yes No
Have you felt little or no pleasure in things you normally enjoy?	Yes No
Have you thought about or made plans to hurt yourself?	Yes No
Have you thought about or made plans to hurt someone else?	Yes No

Family History

Relation	Age	Illnesses
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Sister		
Brother		
Child		
Child		
Other:		

Medical History

Illness	When	Illness	When	Illness	When
Alcoholism		Eczema/Skin Condition		Mononucleosis	
Anemia		Epilepsy/Seizures		Pneumonia	
Anxiety/Depression		Gallstones		Recurrent Infections	
Arthritis		GERD/Acid Reflux		Rheumatic Fever	
Asthma		Heart Attack		Scoliosis	
Autoimmune Disorder		Hepatitis		Sinusitis	
Bronchitis		High Cholesterol		Sleep Apnea	
Cancer:		High Blood Pressure		Stroke	
Chronic Fatigue Syndrome		Irritable Bowels		Substance Abuse	
Crohn's/Ulcerative Colitis		Kidney Stones		Thyroid Issues	
COPD/Emphysema		Mental Delay/Illness		Other:	
Diabetes		Migraines		Other:	

Surgical/Radiological History

Surgery	Date	Surgery	Date	Surgery	Date
Appendectomy		EEG		Liver Scan	
Colonoscopy/Sigmoidoscopy		Eye Surgery		Mammogram/Thermogram	
Coronary Artery Bipass		Hernia Repair		MRI	
CT Scan		Hysterectomy		Orthopedic Surgery	
Dental Surgery		Gall Bladder Removal		Xray	
ECG/EKG		GI Series		Other:	

Women's Health

Menstrual Cycle		Diagnostic Testing and Birth Control	
What was your age when you had your first period?		When was your last Pap?	
What was the first day of your last menstrual period?		Were any of your past paps abnormal?	
Do you have a cycle every month?		If abnormal, what was treatment?	
How long do your cycles normally last?		When was your last mammogram/thermogram?	
Days from beginning of cycle to beginning of next?		When was your last DEXA scan?	
On a scale of 0-10 how painful is menses for you?		Current form of contraception?	
Are you premenopausal or menopausal?		PMS symptoms:	

Pregnancy/OB

Have you been pregnant before?		How many times have you been pregnant?	

Full Term: Premature: Miscarriages: Abortions: Multiple Births: Living children:

Delivery Date	Weeks Along	Labor Hours	Weight	Sex	Delivery Method	Delivery Facility	Complications

Men's Health

Medical History		Past procedures and STD Protection	
Have you ever experienced testicular torsion?		Have you ever had a hernia repair?	
Other testicular problems (lumps, pain, discoloration)?		Have you had a vasectomy?	
Do you have any history of prostate problems?		Have you had a PSA blood test?	
Do you experience excessive urination?		TURP(Transurethral Resection of the Prostate)?	
Do you have urinary incontinence?		Have you ever had a digital rectal exam?	
Do you experience erectile dysfunction?		Do you use protection during sexual activity?	
Do you experience difficulty with ejaculation?		Concerns regarding your testosterone levels?	

Sexual Health

Are you currently sexually active?		How long have you been with your current partner?	
Have you ever been sexually active?		Does your current partner have any other partners?	
How older were you at first intercourse?		Do you use any barriers or STD protection?	
How many lifetime sexual partners?		Do you have any history of STD's or UTI's?	
How many partners have you had in the last 5 years?		Have you ever had nonconsensual sex?	

Other sexual health concerns:

Social				
Do you or have you ever drank alcohol?		Do you or have you ever smoked?		**Please circle any of the following you have used in the past**
If yes, how often?		What do you smoke?		
How much do you drink in one sitting?		How often do you smoke?		Marijuana Cocaine
Do you feel like you should drink less?		How much do you smoke?		Ecstasy Benzodiazepines
Lifestyle				Hallucinogens Heroin
Do you follow a special diet?		Hours you are sleeping per night?		Methamphetamines Opiates
Do you drink caffeinated drinks?		Do you take naps?		Anabolic Steroids
How much do you exercise?		Do you feel rested after sleep?		Other:
Do you have fitness concerns?		Do you have hobbies you pursue?		

Household			
How old is your home?		Who do you live with?	
Do you drink city or well		Do you have pets? (Please Describe)	
Are you exposed to mold at home?		Are you exposed to dangerous chemicals?	

Please include any additional comments or concerns you may have:

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