Amy S. Elder APRN, WHNP-BC
591 N Knik Street, Suite E
Wasilla, Alaska 99654
Phone: 907-203-0044 Fax: 907-331-0505
Email: office@karisalaska.com

PATIENT DEMOGRAPHIC INFORMATION

Full Legal Name _____ Date of Birth_____
Previous/Maiden Name_____ Nickname _____
Social Security # _____ Cell Phone _____Other Phone _____
Mailing Address _____
City _____ State _____ Zip _____ Preferred Pharmacy_____
Email _____ Gender _____
Marital Status _____ Occupation _____
Please check appropriate box(es): □African American □Alaskan Native □Asian □Caucasian □Hispanic □Mediterranean □Native American □Northern European □Other_____

Referring Provider _____ How did you learn about us? _____

Emergency Contact_____Relationship_____Phone Number_____

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

(Please provide appropriate supporting paperwork)

Legal Guardian_____ Date of Birth_____
Relationship to Patient_____ Phone (If different from above) _____
Address (If different from above) _____
Primary part to contact for billing (circle one): **YES NO**

INSURANCE INFORMATION:

Billing preference (circle one): *Insurance *Medicaid (Includes Denali KidCare) *Medicare *Self Pay

PLEASE PRESENT PHOTO ID AND INSURANCE INFORMATION TO FRONT DESK TO BE COPIED IN ADDITION TO COMPLETING THE FOLLOWING:

Primary Insurance _____Insurance ID#_____Group #:_____

Name of Policy Holder_____DOB _____ Relationship _____

Secondary Insurance _____Insurance ID#_____Group #:_____

Name of Policy Holder_____ DOB _____ Relationship_____

Patient Initials:
Date:

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 Privacy 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.

Signature_____ Date _____

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. I also 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**
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____

Signature_____ Date _____

CONSENT FOR TREATMENT

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.

Signature_____Date _____

FINANCIAL AGREEMENT

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 Aurora Billing & Coding as their outsourced billing company and may be contacted by them for payment or additional billing related information.

Signature_____ Date _____

Patient Initials:
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 the primary reason for your visit and/or your main concerns: _____

_____

_____

Please list any other providers you may see or have seen in the last 7 years. This will help coordinate your care.

Office Name	Provider	Reason for Visit	Treatment
Example: Mat-Su Integrative	*Dr. Ty Vincent*	*Allergies, Hormones*	*Hormone Replacement Therapy*

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Do you currently feel safe in your home and with your family? YES NO

Please circle or check next to any Past Medical and Surgical History that apply and when it was diagnosed:

Illnesses	When		When		When
Alcoholism		Eczema/other skin issues		Mononucleosis	
Anemia		Epilepsy or 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 delays/illness		Other:	
Diabetes		Migraines		Other:	

Patient Initials:
Date:

Injuries	When	Diagnostic Studies/Imaging	When
Back injury		Barium Enema	
Broken:		Bone Scan	
Head Injury		CAT Scan of Abdomen	
Neck Injury		CAT Scan of Brain	
Other:		CAT Scan of Spine	
Other:		Chest X-Ray	
Operations/Surgeries		Colonoscopy	
Appendectomy		ECC/EKG	
Dental Surgery		Liver Scan	
Eye Surgery		Mammogram/Thermogram	
Gallbladder		Neck X-Ray	
Hernia Repair		NMR/MRI	
Hysterectomy		Sigmoidoscopy	
Tonsillectomy		Upper GI Series	
Elective Surgery		Other:	
Other:		Other:	

HOSPITALIZATIONS:

Why were you hospitalized?	Where	When	How Long

MEDICATIONS: I consent to my medication history to be imported: **YES NO**

Medication Name	Dosage	Date Started

Patient Initials:
Date:

ALLERGIES: include food, drug, and environmental allergies with start dates and reactions.

Allergy	Reactions	Onset Date

SUPPLEMENTS: including Tylenol, Tums, and Over the Counter (OTC's) Medications

Vitamin/Mineral/Supplement Name	Dosage	Start Date

BIRTH AND CHILDHOOD

Place of Birth: _____ Birth Weight: _____ Childhood Hometown:_____

Were you born full term? Weeks?		How were you delivered?	
Were you breastfed?		Delivery presentation?	
Prenatal or neonatal complications?		Rh incompatibility factors?	
Any tobacco, alcohol, or drug use by mother?		Any recurrent childhood infections?	
Did your mother take Prenatal Vitamins?		Comments:	

Did you receive all your childhood vaccines? **YES/NO**
Do you get yearly Flu Vaccines? **YES/NO**
Date last flu vaccine:_____
Did you receive a Gardasil or alternative HPV Vaccine? **YES/NO**
If yes, did you get the complete series? **YES/NO**
Date of last HPV vaccine: _____
Did you get any COVID shots? **YES/NO** if yes, what type:_____
Date of doses: _____ Any other vaccines? _____

Patient Initials:
Date:

OB/MENSTRUAL(Please fill out even if not currently cycling)

Age at onset of menstrual cycles? _____ First day of ***last*** menstrual cycle_____ Pain scale 1-10? ____

Monthly Cycles? **YES/NO** Date of prior cycle: _____ Average length of cycles_____

Average days between cycles_____ Any PMS symptoms?_____

Date of Last Pap_____ Any abnormal PAPS? **YES/NO** Explain_____ Have you ever been sexually active? **YES/NO** Currently sexually active? **YES/NO** Age at 1st intercourse_____

Was sex consensual? **YES/NO**

Have you ever had non consensual sex? **YES/NO** How many lifetime sexual partners? _____

How long with your current partner? _____ How many partners have you had in the last 5 years? _____

Does your current partner have any other partner? **YES/NO**

If yes, how many partners have they had in the last year? _____

Do you have any issues or concerns with sexual function? _____

Any history of STI's, recurrent vaginal infections, or urinary tract infections? **YES/NO** If yes, when and what type?

_____

Contraceptives Use (including sterilization)? **YES/NO** If yes, what are you using: _____

How long have you been using this method:_____

If No, are you interested in contraception counseling or family planning? **YES/NO**

Have you ever been pregnant? **YES/NO** _____

Total number of pregnancies:

___Full Term ___Premature ____Miscarriages ___ Abortions ___ Multiple Births ___ Living Children

Delivery Date	Weeks Along	Labor Hours	Birth Weight	Sex	Delivery Method	Facility of Delivery	Complications YES or NO	Comments:

Are you Pre-menopausal? **YES/NO/UNSURE**

Are you menopausal? **YES/NO/UNSURE** Age of Menopause:_____

Are you having any perimenopausal or menopausal symptoms: **YES/NO**

If yes, please list symptoms:_____

_____

Have you ever been on Hormone Replacement Therapy (HRT) in the PAST? **YES/NO**

If yes, when and what kind? _____

_____

Patient Initials:

Date:

LIFESTYLE AND SOCIAL INFORMATION

Have you ever used alcohol? **YES/NO** Current Use: **YES/NO** If yes how often do you now drink alcohol?

Alcohol	Social/Occasional/Light/Heavy	Amount	Last Use	Glasses, Bottles, Drinks, Cans	Day, Week, Month
Beer					
Wine					
Liquor					

Have you, or do you use Marijuana? **YES/NO** If so, how often_____

Do you or have you used any nicotine products? **YES/NO**

Past use: Amount per day_____ Last Use _____ Type Used _____For how long?_____

Current use: Amount per day _____Type Used_____ For how long?_____

Are you exposed to secondhand smoke regularly? **YES/NO**

Have you, or do you use recreational drugs? **YES/NO** If so, what kind and how often?_____

Have you had any occupational exposures? (i.e. lead, mercury, industrial chemicals) **YES/NO** If so, when and what kind? _____

With whom do you live? (include children, parents, relatives, and/or friends):_____

Do you own any pets or farm animals? **YES/NO** If yes, please list: _____

What kind home do you live in?_____ Age of Home:_____ Well or City water?_____

Does your home require the stairs? **YES/NO**

Do your home have any safety concerns? **YES/NO**

If yes, explain: _____

Who do you rely on for emotional support? _____

Have you or your family recently experienced any major life changes or losses? **YES/NO**

If yes, please comment: _____

_____

Are you on a special diet? **YES/NO** Comments: _____

Do you consume caffeine? **YES/NO** If yes, explain: _____

Do you exercise regularly? **YES/NO** if yes, how often and for how long?_____

How many hours of sleep on average do you get? _____ Do you feel rested when you wake? **YES/NO**

Do you take naps often? **YES/NO**

Do you wear glasses or contacts? **YES/NO**

Date of last eye exam:_____

Date of last dental visit:_____

Do you require the use of hearing aids? **YES/NO**

When was your last hearing test? _____

Patient Initials:

Date:

FAMILY HISTORY

MEDICAL CONDITION *Please mark if Alive* **(A)** *or Deceased* **(D)**	**Mom**	**Dad**	**Sister**	**Brother**	**Child**	**Child**	**Child**	**Mom's Mom**	**Mom's Dad**	**Dad's Mom**	**Dad's Dad**
DOB or Age at time of death											
Alcoholism											
Anemia											
Anxiety											
Arthritis											
Asthma											
Autism											
Autoimmune Disorder											
Bleeding Disorders											
Cancer: Breast											
Cancer:											
Cancer:											
Cleft Lip/Palate											
COPD											
Dementia											
Depression											
Developmental Delay											
Diabetes											
Eczema											
Food Allergy											
Genetic Disorder											
GERD/Acid Reflux											
Glaucoma											
Hay Fever											
Hearing Loss											

Patient Initials:
Date:

MEDICAL CONDITION *Please mark if Alive* **(A)** *or Deceased* **(D)**	**Mom**	**Dad**	**Sister**	**Brother**	**Child**	**Child**	**Child**	**Mom's Mom**	**Mom's Dad**	**Dad's Mom**	**Dad's Dad**
Heart Attack/Coronary Artery Disease											
High Cholesterol											
High Blood Pressure											
Inflammatory Bowel Disorder (Crohn/IBS/UC)											
Kidney Disease											
Migraine Headaches											
Psoriasis											
Psychiatric/Mental Illness											
Scoliosis											
Stroke											
Substance Abuse											
Thyroid Disorders											
Tuberculosis											
Ulcers											
Death before age 56											
Other:											
Other:											

Thank you for taking the time to complete this questionnaire.
Your participation in your health is the most important key to your success.

Patient Initials:
Date: