Appointment:

859 S. Yellowstone HWY
Suite 3201
Rexburg, ID 208-359-2101

Beacon Integrative Medical Center

WELCOME!

Steps for Your Consultation

1. Please fill out all New Patient forms in their entirety.
2. If you have any recent labs (within 12 months), please bring them to your appointment.
3. If you are married or in a relationship, please bring your spouse or significant other with you to your appointment. (There will be much information covered concerning your unique condition as well as the fundamentals of the program.)
4. Please arrive on time.
5. We require a 24 business-hour notice to change or cancel your appointment.

Note: If these steps are followed we will kindly reschedule your appointment. If not, it may compromise the full value of your consultation.

Patient Information

Please fill out completely. Date: _____

Name: _____ Home Phone: ( ) _____

Address: _____ Cell Phone: ( ) _____

City: _____ State: _____ Zip: _____

Email: _____

Birthdate: mm/dd/yyyy _____ Age: _____ Sex: (circle one) M F

Employer: _____ Occupation: _____ Hour / Week: _____

Marital Status: (circle one) M S D W Spouse's Name: _____

Emergency Contact: _____ Home Phone: ( ) _____

Current Medical Doctor/Physician: _____

Doctor/Physician Phone #: _____

Most of our clients are referred to our office by a caring family member or friend. If that is the case for you, who referred you? _____

How did you hear about us? ☐ Newspaper ☐ Presentation ☐ Mailing ☐ Website
☐ Sign ☐ Mailing ☐ Other: _____

Initial Consultation

Main Complaints or Concerns: 1) _____ 3) _____

2) _____ 4) _____

How long have you suffered with these problems? _____

Any other complaints? _____

_____

Would you like improvement with any of the following:

- ☐ Digestion: Reflux, Gas, or Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy
- ☐ Low Libido
- ☐ Allergies
- ☐ Heart Disease
- ☐ Diabetes

What unsuccessful actions have you tried to resolve these problems?

_____

_____

How do these problems interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life in General: _____

Do you know how these problems may have started? _____

How have you take care of your health in the past?

- ☐ Medications
- ☐ Routine medical
- ☐ Exercise
- ☐ Diet and Nutrition
- ☐ Holstic
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other:

How have these previous methods worked for you? _____

_____

What are you afraid this might be affecting or will affect without change?

- ☐ Job
- ☐ Kids
- ☐ Marriage
- ☐ Sleep
- ☐ Freedom
- ☐ Future abilities
- ☐ Finances
- ☐ Time

Where do you see yourself in the next 3 to 5 years if these problems aren't taken care of? Please be specific: _____

_____

What would be different or better without these problems?

- ☐ Diminished stress
- ☐ More energy
- ☐ Outlook
- ☐ Confidence
- ☐ Relationship with partner
- ☐ Sleep
- ☐ Work
- ☐ Self esteem
- ☐ Family
- ☐ Sense of well-being

Initial Consultation (cont'd)

Rate on a scale of 1 to 10 (10 being highest):

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and will enjoy a mentor in helping you?

_____ How prepared are you to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Please check and/or number all of the symptoms that you are experiencing:

0 = Never 1 = Mild / Rare / Occasional 2 - Moderate / Regularly 3 = Severe / Very Often

Section 1 — GI

_____ Belching or gas within 1 hour of a meal

_____ Heartburn or acid reflux

_____ Bloating or gas shortly after eating

_____ Bad breath (Halitosis)

_____ Hurried eating habits

_____ Feel like skipping breakfast

_____ Feel better if you don't eat

_____ Fingernails chip, peel, or break easily

_____ Stomach pains or cramps

_____ Use indigestion/acid blocking meds

_____ Undigested food in stools

_____ Diarrhea after meals

Section 2 — LV, GB

_____ Pain between shoulder blades

_____ Greasy or high fat foods cause distress

_____ Nausea

_____ Light or clay-colored stools

_____ Bitter metallic taste in mouth, especially in the morning

_____ Reddened skin, especially on palms

_____ Easily intoxicated by alcohol

_____ Unexplained itchy skin

_____ History of drug or alcohol abuse

_____ History of hepatitis

_____ Long-term use of prescription medications

_____ Chronic fatigue or fibromyalgia

_____ Sensitive to chemicals (e.g., perfume, clean-ing solvents, paint, insecticides, car exhausts, gasoline etc)

_____ Dry or flaky skin and/or hair

_____ History of gallbladder attacks or stones

_____ Gallbladder removed? (YES or NO)

Section 3 — SI

_____ Food allergies or sensitivities

_____ Abdominal bloating 1-2 hours after eating

_____ Specific foods make you tired or bloated

_____ Pulse speeds up after eating

_____ Airborne allergies (e.g. hay fever)

_____ Stool undigested, foul smelling, mucous-like, greasy or poorly formed

_____ Are there foods you could not give up? (Y/N)

_____ Sinus infections/stuffy nose

_____ Canker sores in mouth

_____ Alternating constipation and diarrhea

_____ Nausea and/or vomiting

_____ Suffer from hives

_____ Pain, tenderness, soreness on the left side under rib cage, bloated

Initial Consultation (cont'd)

Please check and/or number all of the symptoms that you are experiencing:

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Section 4 — LI

_____ Feeling bowels don't completely empty

_____ Diarrhea, loose stools, not well-formed

_____ Constipation

_____ Coated tongue, "fuzzy" debris

_____ Feel worse in musty or mouldy atmosphere

_____ Fungus or yeast infections (e.g., nail fungus, athletes foot, thrush)

_____ Stools hard or difficult to pass

_____ Anus itches

_____ Blood in stools

_____ Mucus in stools

_____ More than 3 bowel movements per day

_____ Less than 1 bowel movement per day

_____ Use laxatives

_____ Irritable bowel or mucus colitis

_____ Pass large amounts of foul smelling gas

_____ Bad breath or strong body odors

Section 5 — CV

_____ Blood pressure above 140/90

_____ High cholesterol

_____ Family history of heart disease

_____ Are you overweight? (YES or NO)

_____ Do you exercise?

_____ Poor circulation

Section 6 — Immune/Allergic

_____ Post nasal drip

_____ Runny nose / allergies

_____ Cough which produces mucus

_____ Frequent infections: ear, sinus, lung, skin, bladder, kidney

_____ Itchy skin or rash

_____ Cysts, boils, or acne

_____ Frequent colds or flu

_____ History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis, or other chronic viral condition

Section 7 — Men's Health

_____ Prostate problems

_____ Difficult to start and stop urine stream

_____ Pain or burning sensation while urinating

_____ Decrease in libido

_____ Waking regularly to urinate at night

_____ Decrease in fullness of/ maintaining erections

_____ Decrease in physical stamina

_____ Increased fat distribution in chest and hips

_____ Decreased "drive" and motivation

_____ Spells of mental fatigue

_____ Inability to concentrate

_____ Episodes of depression

_____ Muscle soreness

_____ Unexplained weight gain

_____ Sweating attacks

_____ More emotional than in the past

Initial Consultation (cont'd)

Please check and/or number all of the symptoms that you are experiencing:

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Section 8 — Women's Health

_____ Depression during periods
_____ Mood swings associated with periods - PMS, depressed, irritable
_____ Alternating menstrual cycle lengths
_____ Excessive menstrual flow
_____ Minimal blood flow during periods
_____ Skipped periods
_____ Extended menstrual cycle, greater than 32 days
_____ Shortened menses, less than every 24 days
_____ Hair loss / thinning
_____ Breast fibroids - benign masses
_____ Vaginal discharge and itchiness
_____ Vaginal dryness
_____ Hot flashes
_____ Endometriosis
_____ Uterine fibroids
_____ Breast pain and tenderness associated with cycle
_____ Pain and cramping during periods
_____ Acne breakouts during periods
_____ Are you pre-menopausal or menopausal? Y/N

Section 8.1 — Women's Health (Menopausal)

_____ Hot flashes
_____ Mental fogginess
_____ Disinterested in sex; low libido
_____ Mood swings
_____ Depression or anxiety
_____ Painful intercourse
_____ Shrinking breasts
_____ Facial hair growth
_____ Acne
_____ Increased vaginal pain, dryness, or itching

Section 9 — ADR

_____ Insomnia
_____ Slow starter in the morning
_____ Feel wired or jittery when drinking coffee
_____ Clench or grind teeth
_____ Calm on the outside, troubled inside
_____ Become dizzy when suddenly standing up
_____ Cannot fall asleep
_____ Perspire easily
_____ Under high amounts of stress
_____ Crave salty foods
_____ Muscles easily fatigued
_____ Chronic fatigue, or feel drowsy often
_____ Afternoon yawning
_____ Afternoon headache
_____ Allergies and/or hives
_____ Wake up tired even after 6+ hrs of sleep

Initial Consultation (cont'd)

Please check and/or number all of the symptoms that you are experiencing:

0 = Never 1 = Mild / Rare / Occasional 2 - Moderate / Regularly 3 = Severe / Very Often

Section 10 — THY

_____ Tired, sluggish

_____ Weight gain even with low- calorie diet

_____ Require excessive amounts of sleep to function properly

_____ Depression, lack of motivation

_____ Feel cold - hands, feet, all over

_____ Gain weight easily

_____ Outer third of eyebrow thinning

_____ Thinning of hair on scalp, face, lower legs or genitals or excessive falling hair

_____ Morning headaches that wear off as the day progresses

_____ Mental sluggishness

_____ Dryness of skin and/or scalp

_____ Difficult, infrequent bowel movements

Section 10.1 — HYPER THY

_____ Heart palpitations

_____ Inward trembling

_____ Increasd pulse, even at rest

_____ Nervousness and emotional insomnia

_____ Night sweats

_____ Difficult gaining weight

Section 12 — INS. RESIST.

_____ Fatigue after meals

_____ Crave sweets during the day

_____ Eating sweets does not relieve cravings for sugar

_____ Must have sweets after meals

_____ Waist girth is equal or larger than hip girth

_____ Frequent urination

_____ Increased thirst and appetite

_____ Difficult losing weight

Section 13 — HYPOGLYC

_____ Crave sweets during the day

_____ Irritable if meals are missed

_____ Depend on coffee to keep going or get started

_____ Eating relieves fatigue

_____ Feel shaky, jittery, tremors

_____ Agitated, easily upset, nervous

_____ Get lightheaded if meals are missed

_____ Blurred vision

Food and Lifestyle Factors

Consider the typical week, how much of the following do you normally consume?

Alcohol beverages: _____ Water/day: _____

Caffeinated beverages a day: _____ What type? _____

How many times you eat out a week: _____ Where? _____

Please give an example of what you typically eat for each meal:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

List the *three* healthiest foods you eat during a typical week:

_____

List the *three* most unhealthy foods you eat during a typical week:

_____

Do you smoke? Y/N

Rate your stress level on a scale of 1-10 during the average week: _____

Avg # of hours you sleep per night? _____ # of times you wake up at night? _____

How many times do you exercise per week? _____ Type(s) of exercise: _____

Medications & Supplements

Medication Name	Dose	Frequency	Taken for	Date Started

Supplement Name	Dose	Frequency	Taken for	Date Started

Family Health History

Please review the conditions listed below and indicate those that have occurred with a family member.

C = Current Problem P = Past Problem Leave blank those that do not apply.

	Father	Mother	Spouse	Siblings or Children		
Condition	Age:	Age:	Age:	Age:	Age:	Age:
Addiction / Alcoholism						
Allergies / Asthma						
Arthritis						
ADHD						
Cancer						
Colitis (Ulcerative colitis or Crohn's)						
Dementia/Alzheimer's						
Depression/Anxiety						
Diabetes						
Disc problems / Back trouble						
Eczema						
Emphysema						
Epilepsy						
High blood pressure						
High cholesterol						
Insomnia						
Irritable Bowel Syndrome (IBS)						
Kidney disease						
Obesity						
Poor circulation						
Psoriasis						
Stroke / Heart attack						
Other:						

Additional Comments:

Hospitalization

Date	Reason

Surgeries

Date	Reason

Allergies

Medications:

Food:

Environmental:

What Else Would You Like Us to Know About You?

Thank You!

Beacon Integrative Medical Center

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-en-

forcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer: Dr. Brett Appleby NMD

859 S. Yellowstone Hwy, Suite 3201

Rexburg, ID 83440

I hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices, and I acknowledge that I have been given the right to review this document prior to signing this consent. I understand that **Beacon Integrative Medical** Center has the right to change its Notice of Privacy Practices from time to time, and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my, my child's and/or my family's protected health information. I understand that this information can and will be used to: conduct, plan, and direct my (or my child's) treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that, in order to maintain communications with me about my (or my child's) health status and treatment, staff members from **Beacon Integrative Medical** Center may from time to time communicate with me via electronic mail and/or conventional postal delivery by the United States Postal Service. I understand that transmissions by either channel may be subject to un-authorized and illegal interception, and I hereby hold harmless **Beacon Integrative Medical** Center and there staff members, individually and collectively, for any damage or liability should such interception occur.

I understand that I may request in writing that the office should restrict how my private health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that the office is not required to agree to my requested restrictions, but, if agreement is verified in writing, then the office is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the office has already taken action relying on this consent.

Signature _____ Date _____

Print Name _____