Creek Stone Integrated Medical
3501 SW 45th Ave, Ste T
Amarillo, TX 79109
806-355-3000

Patient Information

Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No Which pharmacy do you use? _____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Group No· _____ Ins Id # _____

Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR/PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

What is main reason for seeking treatment? _____

What, if anything has made the problem worse? ❑ driving ❑ walking ❑ working ❑ bending ❑sports ❑ sleeping

What, if anything, has made the problem better? ❑ rest ❑ice ❑heat ❑elevation ❑NSAIDS ❑ pain meds

History of Present Injury/Illness:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

_____

_____

_____

Medical History:

❑ Hypertension	❑ Heart Disease	❑ Migraines	❑ Liver Disease	❑ Rheumatoid Arthritis
❑ Diabetes	❑ Pinched nerve	❑ Cancer	❑ Kidney Disease	❑ Fibromyalgia
❑ High cholesterol	❑ Herniated disc	❑ Ulcers	❑ Osteoporosis	❑ Thyroid problems
❑ Pacemaker	❑ Stroke	❑ Arthritis	❑ Bleeding Disorders	❑ Other _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary doctor? _____

Please list any medications you are currently taking **(Be sure to include dosage and frequency)** _____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Please list any allergies: _____

Please list any surgeries and/or hospitalizations you have had **(type & date)**: _____

_____

_____

Approximate date of last flu vaccine: _____ **WOMEN ONLY**: Date of LMP:_____ Any possibility of pregnancy: YES or NO

Is there a family history of any of the following conditions? **(Indicate family member including parents, grandparents & siblings)**

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Intake of the following:

Cigarettes _____ packs/day Alcohol _____ drinks/week Caffeine _____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Occupation _____:

Does work involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____
Reviewed by: _____ **DATE** _____

Review of Systems

Name_____ **Date**_____

Please mark if you have experienced any of these symptoms within the last month:

Y	N	
		Neurological
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	
		Skin
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Please check ALL options you have previously tried to assist in above symptoms:

____ Over the counter medication
____ Prescriptions
____ Dietary Changes
____ Exercise/Physical Therapy
____ Consult with specialist
____ Supplements
____ Alternative medication/treatment therapies
____ Acupuncture

Have you ever had any type of food sensitivity or vitamin/mineral testing done? ❑ Yes ❑ No
If yes, what? _____ When? _____

Consultation History

Patient Name: _____ Date: _____

What is your major health problem _____

1. _____
2. _____
3. _____

Where does it hurt: _____

How long have you been suffering from this problem? (Major complaint) _____

How often do you find yourself suffering from this problem: (Each complaint)

1. _____
2. _____
3. _____

What does it feel like (Sharp, dull, achy, burning, etc.) _____

Was there an earlier accident, injury that is directly related to this problem? (fall, auto injury, work injury, sports injury, repetitive motion on the job).

_____

_____

Since the time you have began suffering from this problem, what if anything, has helped? (i.e. Ice, heat, rest, over the counter meds, prescriptions, physical therapy, chiropractic, other)

_____

_____

Has anything you've tried thus far fixed your problem? ❑ Yes ❑ No

If this problem didn't exist, either partially or totally, what would you really like to be doing? (Hobbies)

_____

_____

On a scale of 1-10, ten being the highest, rate your commitment to getting rid of the problem. _____
Is there anything preventing you from getting this problem taken care of? ❑ Yes ❑ No

Concerns:

*Cancellation Policy:

If you need to change or cancel your appointment please notify us a minimum of 24 hour prior to your scheduled appointment. Failure to do so will result in a $25.00 charge for the missed appointment.

_____ **I understand this policy.**

Signature:_____ **Date:**_____

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. All prescriptions should be refilled by your original prescriber.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribe care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

X_____ _____

Patient's Signature Date

CREEK STONE INTEGRATED MEDICAL
3501 SW 45TH ST., STE T
Amarillo, TX 79109
806-355-3000

CONSENT TO USE PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Creek Stone Integrated Medical or may be disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should receive the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials.

Requesting a Restriction on the Use or Disclosure of Your Information
- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Note that some of your treatment may be performed in an "open" area. Private areas are always available to discuss your health information upon request.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Date

_____ _____
Witness Signature Date