



Integrative Therapies

7E Oak Branch Drive Greensboro, NC 27407
www.integrativetherapies.net
336-294-0910

Hello! Welcome to Integrative Therapies and Integrative Pain Medicine,

We are very happy that you have chosen to partner with the Integrative healthcare team to support your wellness goals.

Accompanying this letter, there are a number of intake forms. We are aware that this may seem like a lot of material to review and respond to, however, please understand that our goal is to be thorough and to provide the best care that we can.

In order for our team to devise a personalized plan of care, it is helpful for us to know a lot about your medical history and your current healthcare needs. Thank you very much for your time and attention to these documents and for bringing your completed forms with you to your first appointment. **Completing the forms prior to your appointment is very important**, and will allow you much more quality time with your evaluating clinician.

Most of the time spent in the initial visit will involve an exchange of information. To highlight some of the important things, we will provide you with a packet of information that you can refer to whenever you need to. The packet can also be used as a place to put any additional handouts that you may receive over the course of your care. If you are coming to Integrative Therapies for physical therapy or biofeedback it is recommended that you bring your packet with you to each visit to support continuity of care.

Because we want to provide a thorough assessment and a treatment plan and give you an opportunity to ask questions, there may only be a small amount of treatment time available during your first visit, especially if you are coming for an initial physical therapy or physical medicine evaluation. If you would like to know more about the services offered at Integrative Therapies, please feel free to explore our website. The physical therapy and physical medicine section will provide you with a description of our rehabilitation services and give you a more detailed idea of what is involved in the evaluation process. More extensive information, about all of our services can be found in the "Services" section or by clicking on the different icons on the home page.

Our goal is to provide you with a very positive therapeutic experience. As you go through your program, please share any thoughts or recommendations you may have about how we can serve you better. If you have not been scheduled for an orientation with the director directly before or after your initial evaluation, please feel free to contact me personally if you have any questions or concerns.

Finally, I would like to invite you to fill out our Patient Satisfaction Survey available in the reception area toward the completion of your program. We look forward to serving you and appreciate your assistance in enhancing the quality of our care.

Yours in good health,

Lori Loveland, M.A.
Director



Integrative Therapies & Integrative Pain Management

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Greensboro, NC 27407
(336) 294-0910

For office use only

Dx 1: _____ 2: _____
3: _____ 4: _____

Patient Information

Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone: Home _____ Cell _____
Email _____

Check here if you would like to receive Email notices on special events.

Age _____ Date of Birth _____ Sex _____

Referring Practitioner _____

Other professionals involved in my health care: _____

Have you had physical therapy, occupational therapy or chiropractic care anywhere else within the last year? _____

If so, where and how many visits _____

Date of Injury if applicable _____

Is this a work-related injury? _____

Patient's Employer _____
Address _____
City _____ State _____ Zip _____
Area Code () Phone _____

Emergency Contact _____
Relationship _____
Address _____
City _____ State _____ Zip _____
Area Code () Phone _____

For Injury & Liability Cases:

Attorney Name _____
Address _____
City _____ State _____ Zip _____
Area Code () Phone _____

Billing Information

Party responsible for payment- Same as above
Different- see below:

Address _____
City _____ State _____ Zip _____

Area Code () Phone _____

Patient's Relationship to Responsible Party:

Self _____ Spouse _____ Child/Minor _____ Parent _____
Other (specify) _____

Communication/Contact Guidelines Requested by Patient:

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. (Please see HIPAA consent form for more detailed information.)

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> O.K. to leave appointment information | <input type="checkbox"/> O.K. to mail to my work/office address |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> O.K. to fax to this number |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> O.K. to leave appointment information | _____ |
| <input type="checkbox"/> Leave message with call-back number only | |

Signatures are necessary to receive treatment and insurance re-imburement.

Permission to Treat/Release of Information

I give Integrative Therapies, Inc. permission to treat me and release information/clinical photographs to my insurance company, attorney, treating physicians and/or beneficiaries:

Signature _____ Date _____

Assignment of Benefits

I authorize payment directly to Integrative Therapies, Inc. for services I receive.

Signature _____ Date _____



Integrative Therapies

7E Oak Branch Drive Greensboro, NC 27407

Patient Consent to Use of Protected Health Information (PHI)

Patient Name: _____ Patient DOB _____

This consent form is provided to you and required under the Health Information Portability & Accountability Act of 1996 (HIPAA).

By signing this form, you grant consent to Integrative Therapies, Inc. (we, us, the practice) to use and disclose your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations, subject to our Privacy Policy, which may change from time to time. The following is a summary of our Notice of Privacy Practices. A complete copy is available upon request at our office.

You and we have rights and responsibilities as follows:

1. We will use and disclose your PHI for the purposes of treatment, payment, and to support other related, defined health care operations. These are called "routine disclosures." If you were referred by another healthcare professional we normally send a letter with our findings and plan of care to that practitioner unless you instruct us otherwise (see #6 below).
2. We will keep your PHI confidential, releasing it only according to our policies. In general, we will release your information to others only if we are referring you for care, if your insurer requires release for payment, or if you direct us to do so. In certain situations, for example under State of NC or Federal law, we may be required to release your PHI.
3. You have the right to request to inspect and obtain a copy of the PHI we keep regarding you or regarding someone for whom you are the guardian. We are permitted to charge you a reasonable, cost-based fee for the copy or any additional interpretation of the PHI.
4. You have the right to request that we amend the PHI we keep regarding you or regarding someone for whom you are the guardian.
5. You have the right to request a list of non-routine disclosures of your PHI or the PHI of a person for whom you are the guardian that we have made to other parties after April 14, 2003.
6. You have the right to request that we limit the disclosures of your PHI. We are not required to accept that limit but, if we do so, we will be bound by our agreement with you.
7. You have the right to request specific confidential communications within our office. We are not required to accept that limit but, if we do so, we will be bound by our agreement with you.
8. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance upon your consent previously granted.

Our complete Notice of Privacy Practices is posted in our office and available to you upon request. Our privacy policy is subject to change from time to time. If we change our policy, you may also obtain a copy of the revised Notice by contacting the office.

Signature: _____ Date _____

INTEGRATIVE THERAPIES – FINANCIAL POLICY

Thank you for choosing Integrative Therapies as your health care provider. The following information offers some guidelines regarding our financial policy.

- If you are intending to have insurance claims filed in connection with your therapy at our office, we need to have a copy of your insurance card and a photo ID (Please bring these with you at your first visit).
- Our administrative staff will typically check your benefits prior to your first visit and will submit insurance claims to those companies with which we have contracts and with those companies that offer out-of-network benefits where we do not have a contract.
- As a courtesy, Integrative Therapies will also submit claims for secondary insurance when appropriate.
- Integrative Therapies is not a Medicare or Medicaid provider.
- **Please be prepared to pay any co-pays at the time services are rendered.**
- Please be prepared to pay any deductible at the time of your visit. If your deductible is particularly cumbersome, one of our administrative staff members will be happy to assist you with a payment plan.
- For those clients that are coming “self pay” (i.e. no insurance is being filed for services) payment is expected at the time that services are rendered.
- Please be aware that **you are ultimately responsible for the timely payment of your account.** This may include non-covered services not paid by your insurance company.
- A \$40.00 fee will be charged for any returned checks.
- Past due accounts of 90 days or more may be subject to collections.
- Except in cases of emergencies, **we require a minimum 24 hour notice if you cannot keep your scheduled appointment.** We reserve the right to charge for appointments canceled or broken without a 24 hour advance notice. Our fee for missed appointments (those without a 24 hour cancellation) is \$45.00 per session hour.
- For your convenience, we accept cash, personal check, MasterCard, Visa, Discover Card and American Express.

If you have any questions regarding our policy, please feel free to ask us. We are here to help you!

I have read and agree to the conditions as outlined: (Please sign and return to clinic)

Name (Printed)

Signature

Date

Integrative & Rehabilitation Medicine Health Questionnaire

7 E Oak Branch Drive, Greensboro, NC 27407
 Ph: (336) 294-0910 Fax: (336) 218- 0294

Initial Appointment: Integrative Medicine (MD)
 Physical Therapist Biofeedback Acupuncture

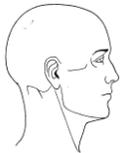
Name: _____ Birthdate _____ Age _____ Date _____

Sex: M F Occupation: _____ Retired Yes ___ No ___

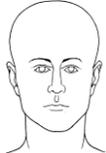
Social status: Single ___ Married ___ Divorced ___ Widowed ___

Children: No ___ Yes ___ Number _____ Do you live alone? Yes ___ No ___

Please shade in areas where you have pain and discomfort. Shade in more darkly those areas that have the greatest discomfort.



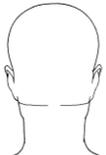
Right



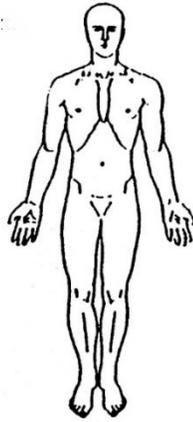
Front



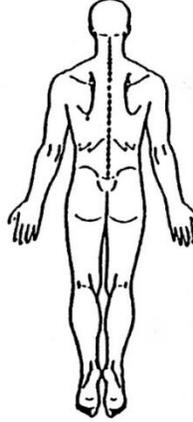
Left



Back



R Front L



L Back R



Right Side



Left Side

Please check the boxes for any symptoms you are experiencing.

	Left	Right	Pain	Radiate	Stiffness	Numbness	Tingling	Burning	Dull	Aching	Sharp	Frequency	Date of Onset
Neck													
Shoulder													
Arm													
Mid Back													
Low Back													
Hip													
Leg													
Knee													
Wrist/Hand													
Ankle/Foot													
Jaw													
Head													

What is your main concern? Describe this in as much detail as possible, including how it began, whether it is constant or intermittent, etc _____

Please circle a number for the LEAST pain you experience.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Please circle a number for the MOST pain you experience.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

What makes the pain worse? _____

What makes it better? _____

Integrative & Rehabilitation Medicine *Health Questionnaire* pg 2

Please list everything you have done to improve this condition and what were the results? _____

If you are having other pain please describe it in detail including dates and how it began _____

Please check (✓) any of the following practitioners you have seen:

Medical Doctor (MD)
 Psychiatrist/Psychologist
 Counselor
 Osteopath/Naturopath
 Chiropractor
 Physical Therapist
 Massage Therapist
 Dentist
 Other _____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

Do you have a primary care physician? No Yes _____

Please list all medications/herbs/supplements that you are taking. (Add additional sheet if necessary)

<i>Medication/Supplement</i>	<i>Dose/Amount</i>	<i>Frequency (per day, week, etc.)</i>	<i>Approximately how long have you been on this?</i>	<i>Reason Prescribed</i>

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Yes No Aspirin Yes No Advil/Motrin/Ibuprofen/other anti-inflammatory _____

Have you EVER been diagnosed as having any of the following conditions? Please circle your **Yes or No** answers.

Yes No Heart Problems	Yes No High Blood Pressure	Yes No Stroke/Aneurism	Yes No Epilepsy
Yes No Circulation Problems	Yes No Asthma	Yes No Thyroid problems	Yes No Diabetes
Yes No Depression	Yes No Emphysema/Bronchitis	Yes No Tuberculosis	Yes No Fibromyalgia
Yes No Kidney Disease	Yes No Hepatitis	Yes No Anemia	
Yes No Rheumatoid Arthritis	Yes No Other arthritic conditions: if yes, describe _____		
Yes No Cancer, if yes describe _____		Yes No Chronic Fatigue Syndrome (CFIDS or ME)	
Yes No Chemical dependency (e.g., alcoholism, recreational drugs)		Yes No Other _____	

Please list all other medical conditions _____

Please list any family members with conditions similar to yours _____

Integrative & Rehabilitation Medicine *Health Questionnaire* pg 3

Please list any *surgeries or other conditions* for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

DATE	REASON FOR SURGERY/HOSPITALIZATION	DATE	REASON FOR SURGERY/HOSPITALIZATION
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Please list any *injuries/traumas* that you have experienced and the approximate dates

DATE	INJURY/TRAUMA	DATE	INJURY/TRAUMA
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Current Health -- Please circle all those that apply:

Constitutional: Fatigue, Fever, chills, change in weight, weakness

Eyes: Blurred or double vision, eye pain, redness of eyes

Ears, Nose & Throat: Difficulty hearing, buzzing in ears, ear pain, runny nose, sore throat, difficulty swallowing, cough, wheezing, sinus problems, dizziness

Cardiovascular: Chest pain, rapid heart-beat, palpitations, irregular heart

Respiratory: Shortness of breath, wheezing, coughing, asthma

Gastrointestinal: Nausea, vomiting, abdominal pain, diarrhea, constipation, heartburn, change in appetite, food intolerances

Genitourinary: Incontinence of bladder, urinary tract infections, urinary tract stones, blood in urine, painful urination, urinary frequency, urinary urgency

Musculoskeletal: Muscle pain, joint pain, joint swelling, joint stiffness, neck or back pain

Skin: Rashes, sores, ulcers, itching, scaling, change in color or temperature or texture of your skin, easy bruising, easy bleeding, scars, rashes, age spots

Neurological: Seizures, weakness, paralysis, numbness, tingling, blackouts, loss of consciousness

Psychiatric: Insomnia, nightmares, depression, anxiety, worry, fear

Endocrine: Easy fatigability, get cold or hot easily, gain weight easily, increased urination

Hematologic/Lymphatic: Easy bruising/bleeding, swollen glands

Allergic/Immunologic: Please list any allergies or sensitivities, including latex, tape adhesives _____

Integrative & Rehabilitation Medicine Health Questionnaire pg 4

Please read each of the twelve items and check the box that most accurately describes your concerns or status during the **past several weeks**. Please feel free to add any information or comments that you think may be helpful. This information will be held in confidence.

<i>Health Concerns</i>	Not at all	A little bit	Moderately	Quite a bit	Extremely	<i>Comments/Specifics</i>
1. Having difficulty getting a good night's sleep.						1.
2. Experiencing fatigue or low energy level						2.
3. Feeling stressed or overburdened						3. Related to <input type="checkbox"/> family <input type="checkbox"/> work <input type="checkbox"/> relationships <input type="checkbox"/> other
4. Having a problem with bowel regularity						4. I have an average of ____ movements per week.
5. Worrying a lot						5.
6. Poor appetite						6.
7. Dealing with domestic violence or threat of it						7.
8. Feeling frustrated or hopeless						8.
9. Eating a lot of processed or prepackaged foods						9. Re: nutrition/diet
10. Feeling I am not getting the support I need from others						10 to <input type="checkbox"/> family <input type="checkbox"/> work <input type="checkbox"/> relationships <input type="checkbox"/> other.
11. Not having enough time to do the things I want to do						11
12. Having symptoms I don't understand						12

1. Has your weight increased or decreased by 15lbs or more in the last 2 months? No Yes
 2. Are you currently pregnant or think you might be pregnant? No Yes If yes, how far along? _____
 3. Do you have leakage when you cough, jump or sneeze? No Yes Other bladder or bowel problems? _____
 4. Do you care for an elderly, ill or disabled person? No Yes If yes, how demanding is this on your time and energy? _____
-
5. Do you smoke? No ___ Yes ___ Packs/Day _____
 6. Recreational Drugs? No _____ Yes _____
 7. Alcohol Consumption? No ___ Yes ___ Drinks per week on average _____ Social Only _____
 8. What is your caffeine intake? (coffee, tea, soft drinks, other) _____ per day
 9. What do you do for exercise? _____ How often? _____
 10. If you work, do you like your job? not at all It's OK, sometimes It's good most of the time very much
 11. Are you a veteran of war? No Yes If so, which one? _____
 12. Have you had any recent life changes such as a change of residence, job status, marriage, births or deaths? _____
 13. How would you characterize your social support system? I have a very good social support system.
My social support system is adequate, but not optimal. I do not have a very good support system or social network.

What do you do for fun and enjoyment? _____

What is your primary goal for today? _____

Is there anything else that you feel you need to know or address today? _____

In addition to your referring practitioner, would you like to send a copy of your report to other medical professionals?
No Yes Please list them: _____