BURNS INTEGRATIVE WELLNESS CENTER

Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

CERTIFIED BRAIN HEALTH COACH

General Patient Intake Form

Personal Information

Name _____ Age _____ Date of Birth _____

Height _____ Weight _____ Gender ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

☐ Married
☐ Divorced
☐ Single
☐ Widow

Children _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email Address _____

Would you like to be subscribed to our newsletter? [no more than 1-2 emails per month] Our newsletter includes health-related articles, Medical Marijuana announcements, and healthy recipes. ☐ Y ☐ N

Spouse _____ Phone _____

Emergency Contact _____ Phone _____

Occupation: _____ ☐ FT ☐ PT

Employer: _____

Primary Care Physician _____ Phone _____

Is it okay if we contact them about your care? ☐ Y ☐ N

How did you learn about our office?

☐ Attorney ☐ Family ☐ Google ☐ Other _____
☐ Mailer ☐ Co-worker ☐ Yelp _____
☐ Friend ☐ Physician ☐ Facebook _____

If referred, by whom: _____

Signature Patient | Patient Name [Printed] | Date

If needed, Signature of authroized representative | Representative Name [Printed] | Relationship to patient | Date

Authorized Facility Signature | Date

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Medical History

Current Medical Complaint

____
____
____

Allergies

☐ No Known Allergies   ☐ Yes - Know Allergies - List All Medications, Foods, Environmental Allergies

____
____
____
____

Medications [please include prescription, herb and over-the-counter]

☐ No Current Medications   ☐ Yes - Current Medications Listed

Medication	Dose	Route: Oral	Injection	Topical	Other	
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________
Medication: ________	Dose: ________	☐	☐	☐	☐	________

If you have a long list, please feel free to bring in a sheet listing all your medications.

Surgeries

☐ No Surgeries   ☐ Yes - List surgeries below

Surgery	Month	Year

Signature Patient ________ Patient Name [Printed] ________ Date ________

If needed, Signature of authroized representative ________ Representative Name [Printed] ________ Relationship to patient ________ Date ________

Authorized Facility Signature ________ Date ________

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Medical History [continued]

Please Check YES or NO for ALL of the following regarding your health

Y N
☐☐ High Blood Pressure
☐☐ Heart Disease / Circulatory Issues [explain] _____
_____
☐☐ Stroke [date] _____
☐☐ Cancer / Tumor [explain] _____
_____
_____
☐☐ Osteoporosis/Osteopenia [where]
_____
_____
☐☐ Taking Birth Control _____
☐☐ STD _____
☐☐ Substance Abuse _____
☐☐ Mental Health Problems _____
_____
_____
☐☐ Sleep Disorders [Sleep apnea, insomnia]
☐☐ Broken bones / Fractures: _____
☐☐ Surgeries / Hospitalizations: _____
☐☐ Other health related issues: _____

Y N
☐☐ Temperature/Pressure Sensitivity
☐☐ Abnormal weight ☐Loss ☐Gain
☐☐ Thyroid ☐Hypo ☐Hyper
☐☐ Bruise easily / Bleeding problems
☐☐ Unusual Spots / Moles
☐☐ Rheumatoid Arthritis
☐☐ Corticosteroid Use
☐☐ Hives, Eczema, Rash
☐☐ Urinary Problems
☐☐ Prostate Problems
☐☐ Menstrual Problems
☐☐ Multiple Sclerosis
☐☐ Dizziness / Fainting
☐☐ Epilepsy / Seizures
☐☐ History of Head Injury
☐☐ Intestinal Disorders [IBS, Ulcers]
☐☐ Asthma / Lung Disease / Difficulty Breathing
☐☐ **Last physical date** _____

Y N
☐☐ Diabetes
☐☐ Stress
☐☐ Pain at night
☐☐ Headaches
☐☐ HIV / AIDS
☐☐ Wear Contacts
☐☐ Night sweats
☐☐ Recent fever
☐☐ Hepatitis
☐☐ Liver Disease
☐☐ Kidney Disease
☐☐ ADD / ADHD

Female Patients Only

Y N
Are you pregnant? ☐☐ # Weeks _____
Are you currently breastfeeding? ☐☐

Physical / Social History

Exercise

☐ None
☐ Moderate
☐ Heavy
Days/week: _____

Work Activity

Y N
☐☐ Sitting
☐☐ Standing / Bending
☐☐ Light Labor
☐☐ Heavy Labor

Drug and Alcohol History

Y N
☐☐ Tobacco Cigaretts / day _____
☐☐ Alcohol Drinks / week _____
☐☐ Caffeine Drinks / day _____
☐☐ Cocaine / Meth
☐☐ Opiates/Prescription, heroin or methadone
☐☐ Hallucinogens [Ecstasy, LSD, Mushrooms]
☐☐ Other _____

Y N NA
Would you like help quitting? ☐ ☐ ☐

General

Y N
☐☐ High Stress _____

_____ _____ _____
Signature Patient | Patient Name [Printed] | Date

_____ _____ _____ _____
If needed, Signature of authroized representative | Representative Name [Printed] | Relationship to patient | Date

_____ _____
Authorized Facility Signature | Date

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Medical History [continued]

Family History

Mother's Side		Father's Side	
Y	N	Y	N
☐	☐ Cancer [type] _____	☐	☐ Cancer [type] _____
☐	☐ Heart Disease - Age _____	☐	☐ Heart Disease - Age _____
☐	☐ Stroke - Age _____	☐	☐ Stroke - Age _____
☐	☐ High Blood Pressue	☐	☐ High Blood Pressue
☐	☐ Diabetes	☐	☐ Diabetes
☐	☐ Rheumatoid Arthritis	☐	☐ Rheumatoid Arthritis
☐	☐ Other _____	☐	☐ Other _____

Cancellation Policy

To better serve our patients, we require 24-hour notice if an appointment is to be canceled or rescheduled. This will ensure maximum availability to all patients who need to see us.

We will charge a $50 fee for any appointment canceled or rescheduled with less than 24-hours notice.

Prescription Refill Policy

Burns Integrative Wellness Center will call in prescription refills within 48 hours of receiving the request on business days, Monday through Friday, except for holiday schedules. Please plan your refills accordingly.

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Signature Patient	Patient Name [Printed]		Date
If needed, Signature of authroized representative	Representative Name [Printed]	Relationship to patient	Date
Authorized Facility Signature			Date

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Consent for Use and Disclosure of Health Information

We here at Burns Integrative Wellness Center are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

3. We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Burns Integrative Wellness Center, its staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of Burns Integrative Wellness Center. All health and patient information disclosed to Burns Integrative Wellness Center, its employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA, are complied with.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By signing below, I hereby acknowledge that I have read and understood how my health information may be used and/or disclosed. This Acknowledgement will be filed with my records.

Signature Patient	Patient Name [Printed]		Date
If needed, Signature of authroized representative	Representative Name [Printed]	Relationship to patient	Date
Authorized Facility Signature			Date