Date:_____
Ref:_____

NEW PATIENT HEALTH HISTORY

Name:_____ Date of Birth:_____ Age:_____ Ht:_____ Wt:_____

May leave a Generic Message (Cell, Home, Email) YES NO Preferred Phone Number: (Enter Below)
May leave a Detailed Message (Cell, Home, Email) YES NO _____

Diagnosis: _____

_____

What are your current symptoms (be as descriptive as possible): _____

_____

_____

What is your main focus/priority for cannabis therapy? _____

_____

_____

What makes it better, what makes it worse? _____

_____

Do the symptoms that you are currently experiencing improve with cannabis use? If so, please explain.

_____

_____

How did this condition start? _____

_____

_____

What kind of workup have you had: tests performed, recent abnormal labs.

_____

_____

What treatments have you tried? How well have they worked? _____

_____

_____

Are you in pain? _____ Location, Severity Range, Goal (0/10):_____

_____

CURRENT MEDICAL CARE: Primary Care Provider (name, practice name or location):

_____

Would you like us to send a copy of your office visit note to your PCP or other providers? (Circle) YES NO

Other health care professional(s) you are seeing and for what conditions:

_____

_____

CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/dosage please):

_____

_____

_____

ALLERGIES? (medications, foods, environmental):

_____

_____

LIFESTYLE:

Profession: _____ Daytime Routine/Considerations: _____

Employed (FT/PT): _____ Student_____ Unemployed_____ Disabled_____ Other_____

How many hours of sleep do you get a night?_____ _ Daily Fluid Intake : water:_____ caffeinated beverages:_____

Describe any dietary restrictions being followed/typical intake: _____

_____

How many alcoholic beverages do you drink per week:_____ Tobacco:_____ Drugs:_____

What substances have you used in the past:

Cocaine_____ Heroin_____ RX drug abuse_____ Mushrooms_____ Acid_____ Ecstasy_____ ETOH_____

How much exercise per week (what kind?)

_____

How do you manage stress? On a scale from 0-10, please rate your typical stress level.

_____

Any recent major life changes?

_____

FAMILY MEDICAL HISTORY: (please list any conditions that run in the family, indicate if alive or deceased)

Mother_____

Father_____

Siblings_____

CANNABIS HISTORY

Do you have legal cannabis allowance? _____

Are you currently using cannabis to alleviate any symptoms that you are experiencing? YES NO

If so, which symptoms:

_____

Products (strain, format)_____ Method of Administration _____

Dosage (i.e. 2-3 puffs three times daily, or ounce per week) _____

Have you had any adverse effects from cannabis? (anxiety, depression, paranoia)

_____

==========

NEW PATIENT INFORMATION & CONSENT FORM

Patient's name_____M_____ F_____ Birth Date_____

Patient's address _____

Email:_____

Telephones: home_____ work_____ cell_____

single____ married____ other____ children_____

Occupation _____

Patient's employer or school

_____

Patient's Primary Care Physician (and/or Referring Physician)

_____

Emergency Contact Info:

Name:_____ Relationship:_____

Phone:_____

Referred by:_____

I, _____ understand that payment for services by this office is solely my responsibility, regardless of any insurance coverage I may have. I authorize the release of any medical or other information necessary to process insurance claims, or a release of records to medical review agencies as required by law. I voluntarily and knowingly consent to and request outpatient treatment, which may encompass diagnostic tests and medical treatments deemed by appropriate by the treating physician. I understand that such services are to be performed by the attending physician or by assistants designated by said doctor. I further authorize and consent to assistants and other personnel, to undertake this service and care as indicated by my attending physician.

_____ _____

Signature of Patient, Parent or Guardian Date

Health Insurance Portability and Accountability Act
Holistic Nurse Health Consultation
HIPAA Privacy Practices Notice

On April 14, 2003, a federal law called the "Health Insurance Portability & Accountability Act (HIPAA) took effect. This law governs how health care providers may use and disclose your medical information, and how you can access your own information. HIPAA requires that we notify you of our policy to protect the privacy of your medical information.

This notice of privacy practices applies to staff members at Integrated Holistic Care, Inc. who might handle sensitive health information.

Your personal health information, to include any health information furnished or discussed with us, will be kept in a secure location and will be released to others only when you furnish written consent specifically allowing open sharing.

Your rights regarding your own medical information:

You may request access to review your own medical information at any time, although charges may incur for copies that require administrative support. In accordance with Oregon state and federal laws, we will not release "specially protected information" regarding HIV testing, mental health counseling, or drug and alcohol dependence treatment records without your specific additional consent.

If at any time, you are concerned that we have compromised your medical information privacy, I invite you to discuss your concerns with me directly. Should we be unable to work together to resolve your concerns, you may contact the Secretary of the Department of Health and Human Services in Washington, DC. Your privacy is one of our greatest concerns, and we am committed to the security of your sensitive medical information.

Please let me know if you have any questions or comments about HIPAA and our privacy practices.

Thank you,
Janna Champagne, RN, BSN
Director, Integrated Holistic Care, Inc.