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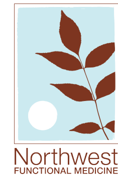

Patient Intake and Medical Review Form

General Information: Date: ____/____/____

Name: ______________________________ **Age:** _____ **Date of Birth:** ____/___/____
Address: __________________________ City/State: _____________________ Zip:__________

Phone: Home: _________________ Work: ________________ Cell: _________________

Gender: M / F **Marital Status:** S / M / D / W / Kid **Social Sec. #** _____-___-______

Guardian/ Emergency Contact/ or Parent Names: ______________________________
Relationship: ________________ Cell #______________

Occupation: ____
Allergies: ____

How did you hear about us? ____

Health Conditions/Complaints/Problems (in order of significance), year and age the condition or symptoms started:
1) ______________________________ __________ ____
2) ______________________________ __________ ____
3) ______________________________ __________ ____
4) ______________________________ __________ ____
Other: ____

Treatments, Medications, Supplements, Herbs, etc. you are taking, how long you have been taking, and effects: (check √ here if you have a separate pre-made list _____)

________________________ _______________________ _______________________
________________________ _______________________ _______________________
____________________________________ ___________________________________
____________________________________ ___________________________________

Previous *Significant* Life or Work Exposures to Chemicals, Solvents, Heavy Metals, Herbicides, Pesticides, etc.

____
____
____
____

Home Water Source: City / Well / Other: ____________

Personal Habits:

Regular Smoker? Y / N / Past, Years _____ Packs per Day ______ Years Off ______
Chew Tobacco? Y / N / Past, Years _______

Alcohol: Regularly (More than 1-2 drinks per week)? Y / N Amount: Light (1-2 drinks/day) ____
Moderate (3-4 drinks/day) _____ Heavy _____ (5 or more)
In Recovery____, Since:_______

Recreational Drug Use? Present / Past / Never
Stimulant or Diet Pill use/abuse? Present / Past / Never __________________

Cravings: Salt or Salty Foods _____ Sugar/Sweets _____ Soda/Pop ____
Water (High Thirst) _____

Exercise Regularly? Y / N Walk ____ Run ____ Hike ____ Bike _____
Swim _____ Weights_____ Treadmill _____
Physical Work _____ Other __________________________
Your Healthiest Weight in Adult Life ________ lbs. **Age:** ______
Current Weight: ________ lbs.

Other Healthcare Providers you see and what you see them for:
1) ____________________ ____________________
2) ____________________ ____________________
3) ____________________ ____________________
4) ____________________ ____________________

Previous Hospitalizations/Surgeries/Serious Illnesses When?

______________________________ __________
______________________________ __________
______________________________ __________
______________________________ __________

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	______	____________________	____________________
Mother	______	____________________	____________________
Siblings	______	____________________	____________________
	______	____________________	____________________
	______	____________________	____________________
	______	____________________	____________________
Spouse	______	____________________	____________________
Children	______	____________________	____________________
	______	____________________	____________________
	______	____________________	____________________
Dad's Mom	_____	____________________	____________________
Dad's Dad	____	____________________	____________________
Mom's Mom	____	____________________	____________________
Mom's Dad	______	____________________	____________________

Review of Systems:

Directions: Read each section and symptom and circle the number that most clearly describes the frequency of symptoms within the past year.
Use the following scale to grade the specific symptoms. If unsure leave blank.

0 = Never	**1 = mild**	**2 = Moderate**	**3 = Severe**	**P = Past**
	(or once a month or less)	(or Several times monthly)	(or Almost constant)	(If just in the past)

Generals and Metabolic:

Fatigue………………. 0 1 2 3 P
Difficulty Gaining Weight 0 1 2 3 P
Difficulty Losing Weight . 0 1 2 3 P
High Appetite ……...… 0 1 2 3 P
Low Appetite ……...… 0 1 2 3 P
Feel Chilled/Cold Easy 0 1 2 3 P
Feel Hot Easy ………. 0 1 2 3 P

Memory Loss………... . 0 1 2 3 P
Anxiety…..................... 0 1 2 3 P
Depression…………... 0 1 2 3 P
Irritability…........... .... 0 1 2 3 P
Insomnia……………... 0 1 2 3 P
Low Blood Sugars….... 0 1 2 3 P
Need snack frequently.0 1 2 3 P

EENT:

Runny Nose……..... 0 1 2 3 P
Sinusitis..…….......... 0 1 2 3 P
Sore Throat…......... 0 1 2 3 P
Horsiness.………… 0 1 2 3 P
Tonsillitis…….....… 0 1 2 3 P
Throat Mucus…..... 0 1 2 3 P
Post Nasal Drip….. 0 1 2 3 P
Cough.................... 0 1 2 3 P

Vision Changes……. 0 1 2 3 P
Dry Eyes…….......... 0 1 2 3 P
Puffy Eyes…….......... 0 1 2 3 P
Watery Eyes……...... 0 1 2 3 P
Hearing Loss ………..0 1 2 3 P
Ear Pain/Infections ... 0 1 2 3 P
Ringing in Ears ……..0 1 2 3 P

GI:

GERD/Acid Reflux... 0 1 2 3 P
Stomach Ulcers? ….0 1 2 3 P
Stomach Pains........ 0 1 2 3 P
Gas/Bloating...…… 0 1 2 3 P
Nausea……………..... 0 1 2 3 P
Vomiting……..........0 1 2 3 P

Constipation...... 0 1 2 3 P
Diarrhea........... 0 1 2 3 P
Hemorrhoids..... 0 1 2 3 P
Blood in Stool... 0 1 2 3 P

Have you ever had a colonoscopy? Y / N

GU:

Urinary Tract Infections... 0 1 2 3 P
Incontinence/Dribbling…. 0 1 2 3 P
Frequent Urination…....... 0 1 2 3 P
Nighttime Urination…...... 0 1 2 3 P

Burning with Urination.... 0 1 2 3 P
Blood in Urine……........ 0 1 2 3 P
Kidney Stones………..... 0 1 2 3 P
Sexual Difficulties ….......0 1 2 3 P

CV:

Heart Trouble………... 0 1 2 3 P
Chest Pain/Angina...... 0 1 2 3 P
Palpitations…………... 0 1 2 3 P
High Blood Pressure.. 0 1 2 3 P

Shortness of Breath………….. 0 1 2 3 P
Swelling of feet, ankles, hands…0 1 2 3 P
Lower Leg Pain Walking/Hiking...0 1 2 3 P

Respiratory:

Chronic or Frequent Cough…0 1 2 3 P
Asthma……………………….0 1 2 3 P
Wheezing…………………..... 0 1 2 3 P
Shortness of Breath... 0 1 2 3 P
Spitting up Blood…..... 0 1 2 3 P

Musculoskeletal:

Joint Pain....................... 0 1 2 3 P
Joint Swelling/Stiffness... 0 1 2 3 P
Muscle Pain…………..... 0 1 2 3 P
Muscle Weakness.......... 0 1 2 3 P
Back Pain/Injury…….... 0 1 2 3 P
Cold Hands and Feet... 0 1 2 3 P
Muscle Cramps…......... 0 1 2 3 P
Difficulty in Walking…... 0 1 2 3 P

Integumentary:

Skin Rashes…………….. 0 1 2 3 P
Skin Itching……………..... 0 1 2 3 P
Changes in Skin Color….. 0 1 2 3 P
Changes in Hair or Nails…0 1 2 3 P
Varicose Veins …...0 1 2 3 P
Breast Pain …….... 0 1 2 3 P
Breast Lumps....…. 0 1 2 3 P
Breast Discharge... 0 1 2 3 P

Neurological/Psych

Previous Head Injury:…Mild / Mod. / Severe
Age: ______

Frequent Headaches……. 0 1 2 3 P
Light Headed or Dizzy…….0 1 2 3 P
Convulsions or Seizures.... 0 1 2 3 P
Tremors………………….... 0 1 2 3 P
Memory Loss or Confusion. 0 1 2 3 P
Nervous or Anxious…….... 0 1 2 3 P
Depression…………...….... 0 1 2 3 P
Irritability………….....…….. 0 1 2 3 P
Anger……………….....….... 0 1 2 3 P
Insomnia……….....…….. 0 1 2 3 P
Nerve Injuries………………0 1 2 3 P

Hemo/Lymph
Enlarged Glands……………0 1 2 3 P
High Blood Iron Levels……0 1 2 3 P
Bleeding or Bruising Tendency…0 1 2 3 P
Blood Clots……………………….0 1 2 3 P
Anemia……………………….. ... 0 1 2 3 P

Diseases of high blood Iron in family history?
…………..Yes/No………

Endocrine
Place a √ after the appropriate/true condition or symptom
Glandular/Hormone Problems ______
Excessive Thirst or Urination ______
Change in Hat or Glove Size ______
Loss of Head Hair _____
Loss of Body Hair _____
Skin Becoming Dryer _____
Heat or Cold Intolerance _____
High (hard to control) Hunger and
Appetite _____

Female Section Answer what is age appropriate. (Cycles are the number of days from the first day of a period until first day of next period. Periods are the actual days of bleeding):

Age at onset of menses _____ Last Menstrual Period _________

Current length of cycle - _____ / irregular ____

In Menopause _____

Periods- days of bleeding _____ Blood *loss*: light / moderate / heavy / NA (circle)

Cramping: none / light / moderate / severe *PMS*: none / light / moderate / severe

Circle any of the following conditions you have experienced or are experiencing (if you do not know what a word means, you probably have not had the condition):

-Uterine Fibroids -Endometriosis -Adenomyosis -Dysplasia (Abnormal PAP)
-Fibrocystic Breasts -Uterine Cancer -Ovarian Cysts -Ovarian Cancer
-Breast Cancer -Miscarriages -HPV -STD's -Herpes -Yeast Infections
-Vaginal Dryness -Excessive Periods or Bleeding -Anorexia -Bulimia

Number of Children: ______ Number of Pregnancies ______ / NA

Any children over 9 pounds at birth? Y / N

Gestational Diabetes? Y / N

Post Partum Depression or Slow recovery? Y / N

How did you feel during the pregnancy? Better / worse / same (except for being pregnant)

Male Section (answer what is age appropriate)

Nighttime Urination? Y / N How many times per night? _____ Is this an increase from the past? Y /N

Circle any of the following conditions you have experienced or are experiencing (if you do not know what a word means, you probably have not had the condition):

-Loss of Sex Drive or Interest -Loss of Sex Function
-(non-impact)Testicle Pain -Testicle Lumps -Decreased Urinary Strength/Flow
-Prostate Swelling or Infection -Prostate Cancer -Painful Erection
-Decreasing Muscle Strength/Endurance -Elevated PSA -STD's -Herpes

Please Read and Sign

Statement of Free Will and Choices

Patient Name: ___________________________ Date: _____________

FREE WILL: I am here of my own honorable free will, legitimately seeking professional healthcare. By signing this, I document that I am not representing any official agency, organization, or media outlet. I understand that all third-party requests for medical treatment protocols and information must be done in writing. All outside requests will be authorized through legal counsel representing Julie M. Barter ND LLC.
All private and confidential patient medical and laboratory information will be provided to outside sources or to the patient only after receiving a legally valid request (available here) that is signed by that patient.

Patient Signature ______________________ Staff Signature________________

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. We request that if you must cancel your appointments we appreciate a 24 hour notice of cancellation. If you miss your appointments, you compromise the care that we are able to provide you and other patients that may have needed an appointment.

We do make a reminder call a day or two before your appointment. Please be sure we have updated contact information.

Patients who do not show up for their appointment without a call to cancel will be considered a “no show”.

Office appointments which are cancelled with less than 24 hours notice, will be charged a fee.

If you miss a new patient appointment, a wellness exam, or an injection appointment you will be charged $75. If you miss a follow-up appointment, you will be charged $50. These fees will not be covered by insurance.

The Cancellation and No-Show fee must be paid in full before the patient’s next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. If you have questions, please contact us at (406) 863-9300

Signature ___________________________________ Date: ________________

NOTICE OF PRIVACY PRACTICES

Julie M. Barter ND LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

The information privacy practices in this notice will be followed by:

- Any health care professional and staff of The Bridge Medical Center.
- Any organization that we retain to support operation of this practice that has executed an agreement regarding privacy of your protected health information.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records relating to your health that we maintain, whether created by staff or your personal doctor. Your doctor may also create information at a hospital or other medical facility. These facilities may have different policies or notices regarding their use and disclosure of your protected medical information.

We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION

Uses or disclosures that can be made without your authorization or an opportunity for you to object:

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or others who are involved in your care at The Bridge Medical Center. We may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays that are provided by other healthcare organizations.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also share information about you and any insurance information with other health care providers to assist them in getting payment for a service they have provided you.

For Health Care Operations. We may use and disclose medical information about you for the operation of The Bridge Medical Center. These uses and disclosures are necessary to run The Bridge Medical Center and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff.

We may use or disclose medical information about you without your authorization for several other reasons. Subject to certain requirements, we may disclose medical information without your authorization for: (1) public health purposes, including disease, injury, or disability prevention; to report abuse or neglect; to report reactions to medications (2) health oversight audits, investigations, or inspections as authorized by law (3) research studies subject to a special approval process (4) funeral arrangements and organ donation (5) worker's compensation purposes (6) emergency situations; to prevent serious threat to the health and safety of you, the public, or another person.

We also disclose medical information when required by federal, state, or local law, such as in response to a request from law enforcement in specific circumstances, or in response to a subpoena or other valid judicial or administrative orders. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

We may also contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health related benefits, or services that may be of interest to you.

USES OR DISCLOSURES WHEN YOU HAVE AN OPPORTUNITY TO OBJECT

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

In any other situation not covered by the Notice, we will ask for your written authorization before using or disclosing medical information about you. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

YOUR RIGHTS

You have the right to inspect and obtain a copy of medical information about you that may be used to make decisions about your care. You must submit a request in writing. If you request copies, we may charge a fee for the costs of copying, mailing or other related supplies. We may deny your request but you have the right to appeal any such denial.

If you believe that medical information we have about you is incorrect or incomplete, you may request that we amend the information for as long as the information is kept by the organization. Your request must be made in writing. We may deny your request to amend the information if it was not created by us, if we do not maintain the information, or if we determine the information is accurate and complete. You may appeal, in writing, a decision by us not to amend a record.

You have the right, upon written request, to receive a list of instances where we have disclosed medical information about you for purposes other than for treatment, payment, health care operations, or where you specifically authorized a disclosure upon written request. The request must state the time period desired for the accounting, which must be less than 6 years from the date of the request.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. Your request must be made in writing, and must include what information you want to limit, and to whom you want the limits to apply.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint in writing to The Bridge Medical Center or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We may change this notice at any time. The new notice will be effective for all medical information that we maintain at that time, as well as new information after the change occurs. The current notice will be available upon request at The Bridge Medical Center 5938 Highway 93 South Whitefish, MT.

If you have any questions about this notice, please contact:

The Bridge Medical Center / 5938 Hwy 93 South, Whitefish, MT 59937 / 406-863-9300

Effective Date: January 1, 2008

The Bridge Medical Center

5938 Hwy 93 South, Whitefish, MT 59937
Phone: (406) 863-9300
Fax: (406) 863-9301

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of The Bridge Medical Center's Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how the Bridge Medical Center may disclose and use my protected health information.

Patient Name: ____ DOB:__________________

Signature: ____ Date: __________________

If signed by the patient's personal representative, indicate:

a. Name of Signer: ____

b. Relationship to Patient: ____

If acknowledgement not signed, indicate the reason not signed and efforts made to have acknowledgement signed:

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