Northwest Family & Functional Medicine

1232 Whitefish Stage Rd, Kalispell MT 59901
406-751-6833

Date:_____

Name:_____Age:_____Date of Birth:_____
Address: City/State: Zip:.__ _
Phone: _____Cell:_____ Ok to leave message? Yes or No
Gender:_____Marital Status:_____Occupation:_____
Guardian/Emergency Contact Name:_____.Phone:_____
Email: Ok to email messages? Yes or No
Allergies:_____

Health conditions/Complaints/ Problems:	Year	Age

Medication / Supplements / Herbs / Etc:	Dosage	Duration

Have you ever been exposed to Chemicals, Solvents, Heavy Metals, Herbicides, or Pesticides?
f yes, explain: _____

Home Water Source: City Well Other:_____

NW FAMILY & FUNCTION MEDICINE IS COMMITTED TO PROVIDING OUR PATIENTS WITH EXCEPTIONAL CARE. LAST MINUTE CANCELLATIONS PREVENT ANOTHER PATIENT FROM BEING SEEN. **PLEASE CALL (406)751-6833 48-*BUSINESS* HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TO NOTIFY US OF ANY CHANGE OR CANCELLATIONS.** TO CANCEL A MONDAY APPOINTMENT, PLEASE CALL BY 12:00PM FRIDAY. **IF PRIOR NOTIFICATION IS NOT GIVEN, YOU WILL BE CHARGED A $75 NON-REFUNDABLE FEE FOR FOLLOW UP 60 MINUTE APPOINTMENTS OR 50% OF THE VISIT COST FOR VISITS LONGER THAN 60'.** THIS MUST BE PAID IN FULL PRIOR TO SCHEDULING ANOTHER APPOINTMENT. THE PROVIDERS USE AN AI TOOL THAT CREATES A TRANSCRIPT OF THE VISIT TO ASSIST US WITH ACCURACY AND PRESERVING DETAIL, ENSURING OPTIMAL RECORDS SUPPORTING APPROPRIATE DIFFERENTIAL DIAGNOSES AND TREATMENTS ARE CREATED.

Signed:_____Date:_____

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Regular Smoker: Yes/ No/ Past

Chew Tobacco: Yes/ No/ Past

Alcohol: Yes/ No/ Past
How many per week? _____

Exercise Regularly: Yes/ No/ Past
How many times per week? _____

Recreational Drug Use: Yes/ No/ Past

Stimulant / Diet Pills: Yes/ No/ Past

Current Weight: _____

Healthiest Adult Weight: _____

Other Healthcare Providers You See:
And Why

_____
_____
_____
_____

Previous Hospitalizations:
And Approximate Year

_____
_____
_____
_____
_____

Family Medical History

	Age	Disease(s)	Cause of Death
Father			
Mother			
Sibling 1)			
Sibling 2)			
Sibling 3)			
Sibling 4}			
Spouse			
Child 1)			
Child 2)			
Child 3)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

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Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have received a copy ofThe 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:_____Date of Birth:._____

Signature: _____;_____Date: _____

Designation of Personal Representative for Health Information

The Health Insurance Portability and Accountability Act of 1996 ("HIPM") gives you the right to have one or more individuals act as your Authorized Personal Representative to make decisions regarding the use of and sharing of your Protected Health Information ("PHI"). This form provides that Authorized Personal Representative information to The Bridge Medical Center. You can limit the information to be provided to your Authorized Personal Representative and you can cancel this designation at any time.

Designation Section:

I, _____hereby name the following person to act as my Authorized Personal Representative with respect to decisions involving the use and/or sharing of my Protected Health Information.

_____(Printed name of Representative)

_____(Printed name of Representative)

Information Limits: Please Check One

_____My Personal Representative(s) is able to be given all of the privileges that would be given to me with respect to my Personal Health Information

_____My Personal Representative(s) is acting on my behalf only for the following functions:

_____

_____

_____

I understand I may cancel this designation at any time by signing the revocation section of my copy of this form and returning it to Northwest Family and Functional Medicine. I understand that any cancellation can only apply to future disclosures or actions regarding my Personal Health Information and cannot cancel actions taken or disclosures made while the designation was in effect.

Signature: _____Date: _____

Revocation of Personal Representative:

I **no longer want this person(s) to act as my personal representative.**

Signature:._____**Date:**_____

CIRCLE ANY SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS:

Patient Name:._____ **Date:**_____

Generals & Metabolic:

Fatigue
Difficulty Gaining Weight
Difficulty Losing Weight
High Appetite
Low Appetite
Feel Chilled/ Cold Easy
Feel Hot Easy
Memory Loss
Anxiety
Depression
Irritability
Insomnia
Low Blood Sugars
Need Snacks Frequently

Ear Nose And Throat:

Vision Changes
Dry Eyes
Puffy Eyes
Watery Eyes
Hearing Loss
Ear Pain / Infections
Ringing in Ears
Cough
Runny Nose
Sinusitis
Sore Throat
Horsiness
Tonsillitis
Throat Mucus
Post Nasal Drip

Gastrointestinal:

GERD/Acid Reflux
Stomach Ulcers
Stomach Pain
Gas/Bloating
Nausea
Have You Had A Colonoscopy Yes/ No
Constipation
Diarrhea
Hemorrhoids
Blood In Stool
Vomiting

Genitourinary:

Urinary Tract Infections
Incontinence/Dribbling
Frequent Urination
Nighttime Urination
Burning With Urination
Blood In Urine
Kidney Stones
Sexual Difficulties

cardio Vascular:

Chest Pain/Angina
Palpitations
High Blood Pressure
Swelling Of Feet, Ankles, Hands
Shortness Of Breath
Heart Trouble
Leg Pain When Walking

Respiratory:

Wheezing
Asthma
Chronic Or Frequent Cough
Shortness of Breath
Spitting up blood

Musculoskeletal:

Joint Pain
Joint Swelling / Stiffness
Muscle Pain
Muscle Weakness
Back Pain
Cold Hands/Feet
Muscle Cramps
Difficulty In Walking

Integumentary:

Skin Rashes
Skin Itching
Changes in Skin Color
Changes in Hair/Nails
Varicose Veins
Breast Pain
Breast Lumps
Breast Discharge

Neurological/Psych:

Previous Head Injuries? Yes/ No
If Yes, When?
Frequesnt Headaches
Light Headed / Dizzy
Convulsions/ Seizures
Tremors
Nerve Injuries
Confusion
Memory Loss
Nervous/ Anxious
Depression Irritability
Anger
Insomnia

Endocrine:

Glandular/ Hormone Problems
Excessive Thirst or Urination
Change in Hat or Glove Size
Loss of Head Hair
Loss of Body Hair
Dry Skin
Heat/ Cold Intolerance
High/ Hard To Control Hunger
Loss of Appetite
Poor Wound Healing

Hemo / Lymph:

Bleeding Or Bruising Tendency
Blood Clots
Anemia
Enlarged Glands
High Blood Pressure
High Iron Disease In Family

Are You Currently Pregnant: Yes / No

Female Section:

Age At Onset Of Menses_____ Last Menstrual Period_____
Current Length of Cycle _____ Are Your Periods Regular Every Month Yes / No
Are You In Menopause _____ Days Of Bleeding During Period _____
Cramping Light/ Moderate / Severe PMS Light/ Moderate/ Severe

Circle any of the following conditions that you experienced or are experiencing:

Uterine Fibroids	Endometriosis	Adenomyosis	Dysplasia
Fibrocystic Breasts	Uterine cancer	Ovarian Cysts	Ovarian Cancer
Breast Cancer	Miscarriages	HPV	STD's
Vaginal Dryness	Excessive Bleeding	Herpes	Yeast Infections
Anorexia	Bulimia		

Are You Currently Pregnant Yes / No
Number Of Children _____ Gestational Diabetes Yes/ No
Number Of Pregnancies_____ Post-Partum Depression Yes/ No
Any Children over 9 Pounds At Birth Yes/ No Slow Recovery Yes/ No
During Pregnancy how do you feel Better/ Worse/ Same

Male Section:

Nighttime Urination Yes/ No
If Yes, How Many Times Per Night ___ _
Is This An Increase From The Past Yes/ No

Circle any of the following conditions that you experienced or are experiencing:

Loss Of Sex Drive	Testicle **Pain**	Decreased Urinary Strength
Loss Of Interest In Sex	Testicle Lumps	Prostate Swelling
Loss of Sexual Function	Decreased Urinary Flow	Prostate Infection
Prostate Cancer	Painful Erections	Decreased Muscle Strength/ Endurance
Elevated PSA Results	**STD's**	Herpes

PLEASE READ AND SIGN
STATEMENT OF FREE WILL AND CHOICES

Patient Name_____ Date_____

FREE WILL: I *am* here of my own free will, legitimately seeing 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 NORTHWEST FAMILY & FUNCTIONAL MEDICINE. 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 that is signed by the patient/ guardian.

Patient/ Guardian Signature Date

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IV Instructions and Treatment Consent Form

IV Nutrient Therapy is a powerful way to access cells, to accelerate healing and prevent infection. While the use of IV nutrients is safe, in some cases there can be issues and complications. By following our recommendations below, we can minimize the complications and risks by asking you to follow the guidelines for a safe, effective treatment.

I understand that before IV Nutrient Therapy, I need to:

1. Complete blood work (CBC, Comprehensive Metabolic Panel, G6PD, Ceruloplasmin, U/A)
2. Arrive hydrated - if dehydration occurs due to the nutrient IV, you will be given fluids to correct the dehydration.
3. Arrive having eaten a meal or snack or bring snacks with you. Initials: ___ _

I understand that the following will reduce the efficacy of IV Nutrient Therapy and that it may take more treatments to reach optimal health:

1. Cigarette smoking
2. Caffeine consumption increases Vitamin C excretion
3. Poor diet: processed foods, high sugar intake, nutrient deficient diets
4. Heavy metal toxicity Initials: ___

I understand that having a nutrient IV can cause symptoms such fever, fatigue, headaches or nausea. Please call if you have concerns or questions following your IV. Initials:

Safety and Side Effects

As with all intravenous preparations, the vein being used to receive the cocktail can become inflamed, infiltrated or infected. Occasionally, a person will experience a fall in blood pressure, which can be related to magnesium in the IV. Our staff will be present and able to help you by stopping the infusion and/or providing some extra intravenous fluids to help your blood pressure return to normal. Low potassium can occur as potassium shifts from the blood into the cells also related to the magnesium. If you are on medications or have a condition that is likely to cause potassium deficiency, please let us know. These include: diuretics, steroids, beta-agonists, chronic diarrhea or acute episode of diarrhea, vomiting or a patient that is very malnourished. Rare episodes of allergic reactions to thiamine (Vitamin BI) have been reported.

Consent

By signing this consent, you acknowledge that you have read this form, had all your questions answered, are knowledgeable about conventional treatments available for your condition and are aware that the intravenous nutrient therapy is not FDA approved and is considered "unconventional" and/or "controversial" for the above-mentioned disorders. Long-term adverse consequences of these therapies may be possible but are unknown at this time. By signing this consent, I understand these risks and I am willing to accept the risk. I understand that benefits of this treatment will be enhanced by engaging in positive lifestyle changes such as exercise, proper diet and nutritional supplementation that has been recommended by the healthcare provider. I, _____. give my informed consent for intravenous therapy to Dr. _____(who is trained in administering, monitoring and ordering intravenous therapies). It me be recommended, depending on follow-up tests to continue these treatments from time to time to maintain health benefits. I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM AND ALL MY QUESTIONS HAVE **BEEN ANSWERED.** I understand I should not sign this form if intravenous vitamin supplementation therapy, its possible risks and its possible benefits have not been explained to my satisfaction. I further understand that I should not sign this form if I have unanswered questions or if I do not understand anything in this consent form.

Patient Signature Print Name Date