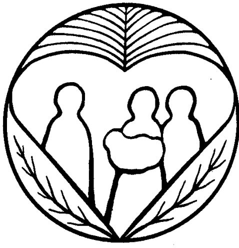


Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

Dear _______________________,

Welcome to the Full Circle Center for Integrative Medicine. We are looking forward to working with you on your journey to optimal health and vitality. In preparation for your initial visit with us, we would like you to complete some paperwork BEFORE your first appointment. This includes demographic and insurance information with a Consent for Treatment, a Health History Questionnaire, an Acknowledgement of Receipt of HIPAA Privacy Information, and a Consent for Use of the Patient Portal (for secure electronic communication.) If you prefer to type directly onto these forms, they are available on our website at www.fullcirclemed.org on the New Patient page.

The Health History Questionnaire is quite detailed. We understand that completing this form requires a substantial amount of your time, however we feel gathering this detailed information prior to the visit allows us to accomplish more with your time in the office and to provide you with the level of holistic health care you deserve. Thank you for your patience with this. Ideally, please return this to us prior to your visit; that will allow us time to review it and to research your condition prior to your visit if needed.

On the day of your visit, please bring the following items with you:

Your completed paperwork if not already sent in

Your insurance card

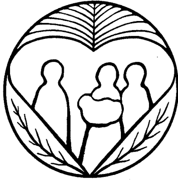
Your current medications and supplements -- IN THEIR BOTTLES

Pertinent medical records, if you have them

Thank you, and take care,

The Full Circle Center

Acknowledgement of Receipt of Notice of Privacy Practices



Full Circle Center for Integrative Medicine
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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

ˆ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

______________________________.

Signed: _______________________________ Date: ___________________________

Print Name: ___________________________

Telephone: ______________________

If not signed by the patient, please indicate:

Relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

Name of Patient: ____

Full Circle Center
4641 Valley East Blvd., #2
Arcata, CA 95521-4630
707-840-4701
Fax 855-420-6321

New Patient Demographic and Insurance Information

Title: ______ Patient Name:_____________________________________ Gender: ________
Address: ____
City: _____________________________ State: __________ Zip code: ____________
Cell phone: _________________ Home Phone: _________________________
E-mail address: _____________________________
I prefer to receive notification of confidential results via: ❒Phone ❒E-mail ❒Snail Mail
Marital Status: ______________________ Employer: ______________________
Date of Birth: ______________________ Social Security Number: ______________________
Preferred Language: ________________ Ethnicity and Race (Optional): ________________

Responsible Party (Person financially responsible for this account, if other than patient):
Title: ______ Name: ___________________________________ Gender: ________________
Address: ____
City: ________________ State: _______ Zip code: ________________________________
Cell phone: ________________________________ Home Phone: ________________________
E-mail address: ____
DOB: ________________ Social Security #: ________________________________

Insurance information
Primary Insurance Carrier Name: ____
Insurance Address: ____
Insurance Phone Number: ____
Group Name: ________________ Group #: ________________________________
Subscriber Name: ______________________ Subscriber ID with Insurance Company: ___________
Subscriber Gender: ___Subscriber DOB: ________________Subscriber SSN: ________________
Subscriber relationship to patient: ________________________________

If the patient is covered by a secondary insurance policy, please complete the information below for coordination of benefits. This will enable the insurance company to process the claim more quickly.
Secondary Insurance Carrier Name: ________________________________
Insurance Address: ____
Insurance Phone Number: ____
Group Name: ________________ Group #: ________________________________
Subscriber Name: ________________ Subscriber ID with Insurance Company: ________________
Subscriber Gender: ___ Subscriber DOB: ________________Subscriber SSN: ________________
Subscriber relationship to patient: ____

If covered by Workers' Compensation or insurance related to an accident, please fill out the information below:

Person responsible for payment: ________________________________

Date of Injury: ____

Industrial Claim #: ____

Name of Insurance Company or Program: ________________________________

Address: ____

Policy number: ____

Were you injured on the job? ________________________________

I hereby give authorization for payment of insurance benefits to be made directly to my Healthcare Provider at the Full Circle Center for Integrative Medicine, and any assisting physicians, for services rendered. This authorization shall remain valid until written notice is given by me revoking such authorization.

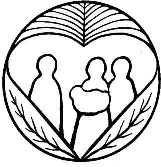
I understand that I am fully responsible for all charges whether or not they are covered by insurance. A service charge of ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.

I understand that nutritional consultation and herbal consultation are not covered by insurance and that there will be a surcharge for these services.

I hereby authorize the release of any medical information needed to secure the payment of benefits. I further agree that a photocopy of this document shall be as valid as the original. I also authorize discussion of my case among the providers at Full Circle.

____

Signature of Patient or Responsible Party Date



Full Circle Center for Integrative Medicine
4641 Valley East Blvd, #2
Arcata, CA 95521
707-840-4701
Fax 855-420-6321

Comprehensive New Patient Health History – Adult

Current Date _____/_____/_____

Name ________________________________ Preferred first name/nickname (if different):______________________

Date of Birth _____/_____/_____ **Birth Gender:** ❒ male ❒ female **Current Gender:** ❒ male ❒ female

Welcome to the Full Circle Center for Integrative Medicine. This questionnaire has been designed so that we can both review your past medical history and other factors in your life that affect your health. The questionnaire makes it possible for us to be more thorough within the constraints of a brief clinic visit.
It is long and detailed! Some of this information may already be in your medical records, but we are going to ask you to repeat it here to be sure we are getting your complete history. Some questions are very personal - if you do not wish to answer these, please skip over them. You may use an additional sheet of paper if needed. All information collected will be kept strictly confidential. Thank you for your patience.

General Health:...❒ excellent ❒ good ❒ fair ❒ poor

Reason why/Problem for which I am coming to be seen:____

If you are well, please let us know what particular preventive concerns you have. If you are not well, please describe the onset of your illness – when was the last time you felt completely well, what was going on in your life at the time the illness started:
____

____

____
What treatments have you tried so far for your problem?
____

____
Is there anything in particular that you are hoping for from this visit? Any specific questions you would like answered?

____
Past Medical Illnesses:

- ❒ accidents, broken bones, other serious injury
- ❒ anemia (low blood count) or bleeding problems
- ❒ lung problems: pneumonia, emphysema, asthma, etc.
- ❒ heart problems, high blood pressure, heart attack, etc.
- ❒ gland problems: diabetes, thyroid trouble, etc.
- ❒ digestion problems: ulcers, diarrhea, heartburn, etc.
- ❒ emotional problems: depression, anxiety, hallucinations
- ❒ high cholesterol or triglycerides
- ❒ allergies (asthma, eczema, hayfever)
- ❒ cancer, including skin_________________(what organ?)
- ❒ liver or kidney problems
- ❒ pain: low back pain, headaches, neuropathyetc.
- ❒ skin disease: eczema, psoriasis, etc.
- ❒ tuberculosis (or positive skin test)
- ❒ nervous system: seizures, MS, pinched nerve
- ❒ sexually transmitted diseases

OTHER (and **dates and details on items checked above**): ____

____

____

____

Your own Birth History: (when you yourself were born)
❒ Term ❒ Premature
❒ Vaginal ❒ Cesarean ❒ Birth Complications:____
❒ Bottle-fed ❒ Breast fed. How long? ______________
Past Surgeries (include approximate dates and types of procedures) or any major **Injuries**: __________________________________

____

Dental History:
Silver Mercury Fillings ❒ No ❒ Yes: (How many?____________________)
❒ Gold Fillings ❒ Root canals ❒ Implants ❒ Other dental issues____

Travel: Have you ever been in (or are you from): ❒ a foreign country? (Where:___________________________)
❒ another region of the United States?
Have you done any wilderness camping? ❒ no ❒ Yes: When?_____________________________
Where were you born? ________________________ Where did you grow up? ____________________________
How long have you lived in Humboldt County?______________________________

Pregnancy: Have you ever been pregnant?...❒ yes ❒ no

Number of :	Date(s):	Number of :	Date(s):
Abortions:	___________________________	C-sections:	___________________________
Miscarriages :	___________________________	Premature births:	___________________________
Live Births:	___________________________	Stillbirths:	___________________________

Problems with prior pregnancies(miscarriage, blood sugar, blood pressure, hemorrhage, etc):______________________
____ Any babies over 8 lb? ....❒ yes ❒ no
Did you Breastfeed? ❒ yes ❒ no For how Long?________________ Any issues with breastfeeding? ___________________________

Past diagnostic tests: (list date and results of tests, if known)
❒ Colonoscopy____________ ❒ Pap smear ______________ ❒ Mammogram ____________ ❒ Eye exam__________
❒ DEXA(bone density)____________ ❒ Heart tests (echo, angiogram, etc.):___________________ ❒ Other_____________________

Immunizations(Mark if ever received, and give approximate date of most recent dose): ❒ Flu shot ________ ❒ Pneumovax ________
❒ Tetanus _______ ❒ TdaP (tetanus with whooping cough booster)________ ❒ Shingles vaccine____________ ❒ Hep B series ____________
❒ Other ____

Current medications (include prescription drugs, over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, herbs, or supplements etc. and indicate dose and how often you take them): ____

____

____

____

____

PLEASE BRING ALL YOUR BOTTLES TO YOUR VISIT!

Have you had prolonged or regular use of:

NSAIDs (advil, aleve, motrin aspirin, etc.)?	❒ yes ❒ no	Tylenol (aceteminophen)?	❒ yes ❒ no
Acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)?	❒ yes ❒ no	Steroids(prednisone)?	❒ yes ❒ no
Frequent antibiotics more than 2 times per year?	❒ yes ❒ no	Long-term antibiotics?	❒ yes ❒ no

Allergies:
Do you have drug allergies?....❒ No ❒ Yes What? (list medication and reaction): ______________________________

____

Do you have any food allergies?....❒ No ❒ Yes What? (list food and reaction):______________________________

____

Which of these significantly affect you?
❒ MSG ❒ Aspartame (nutrasweet) ❒ Caffeine ❒ Garlic or onion ❒ Alcohol ❒ Sulfite containing foods (wine, dried fruit, salad bars)
❒ Preservatives (eg sodium benzoate) ❒ Perfumes/colognes ❒ Cigarette smoke ❒ Exhaust fumes ❒ Other:_____________

Genetics:
Ethnic heritage (if you are comfortable sharing): ❒ African ❒ Asian ❒ European ❒ Ashkenazi ❒ Native American
❒ Mediterranean ❒ Middle Eastern ❒ Other: ____________________________________

Family History:
Are you adopted?...❒ yes ❒ no
Please list medical history for your family members:

Relationship	Name(s)	Age	Living/Deceased	Medical Problems
Mother	________________________	______	____________	____
Father	________________________	______	____________	____

Relationship	Name(s)	Age	Living/Deceased	Medical Problems
Brothers	______________________	_____	___________	____
Sisters	______________________	_____	___________	____

Is there any history in the family of the following illnesses?

(Include mother(M), father(F), sister(S), brother(B), grandmother (GM), grandfather(GF), aunts(A), uncles(U), cousins(C).)

Heart: Who?
- ❒ Heart problems ______
  before age 50? ❒ Yes ❒ No
- ❒ High cholesterol ______
- ❒ High blood pressure ______
- ❒ Sudden Death ______

Hormone:
- ❒ Diabetes ______
- ❒ Thyroid disease ______
- ❒ Polycystic Ovaries ______

Eyes, Ears, Nose, Throat:
- ❒ Glaucoma ______
- ❒ Hearing loss ______
- ❒ Visual Loss ______

Genetic/Birth:
- ❒ Birth Defects ______
- ❒ Metabolic disorders ______

Blood: Who?
- ❒ Bleeding or clotting disorder ______
- ❒ Pulmonary Embolism ______

Mental Health/Substance Abuse:
- ❒ Alcoholism/drug abuse ______
- ❒ Prescription drug overuse ______
- ❒ Attention Deficit Disorder ______
- ❒ Depression ______
- ❒ Schizophrenia ______
- ❒ Smoking tobacco ______

Musculoskeletal:
- ❒ Osteoarthritis ______
- ❒ Osteoporosis ______
- ❒ Rheumatoid arthritis ______
- ❒ Other Rheumatologic disorder______

Genitourinary:
- ❒ Endometriosis ______
- ❒ Polycystic Kidney Disease ______

Neurologic: Who?
- ❒ Alzheimer's ______
- ❒ Migraine ______
- ❒ Epilepsy ______
- ❒ Stroke ______
- ❒ Multiple Sclerosis____

Cancer:
- ❒ Breast cancer ______
- ❒ Colorectal CA ______
- ❒ Pancreatic CA ______
- ❒ Ovarian CA ______
- ❒ Melanoma ______
- ❒ Prostate cancer______
- ❒ Other cancer ______

Lung:
- ❒ Asthma ______
- ❒ COPD ______

Details of above: ____

Other conditions in your family: ____

Social History and Demographics:

Language you prefer: _________________________ Second language: ______________________ Interpreter needed ❒ Yes ❒ No

Marital Status: ❒ Divorced ❒ Married ❒ Partnered ❒ Separated ❒ Single ❒ Widowed

If you are currently married or in a committed relationship, who is your "significant other"? ___________________________

If not, have you ever been married or in a committed relationship?. . . . . ❒ yes ❒ no

Occupation: What is your preferred field of work? ____

Currently ❒ Employed (Employer/job title_________________________) or ❒ Unemployed? (*last worked* _________________)

Work hours per week _____________________

Health concerns regarding your work: ❒ stress ❒ repetitive motions ❒ heavy lifting ❒ dust, fumes, or loud noises ❒ verbal harrassment or abuse ❒ other _________________________

Do you like the work you do? ❒ yes ❒ no

Military Service: ❒ No ❒ Yes ❒ Retired

Education highest level completed:...............................❒ grade school ❒ high school ❒ trade school ❒ college ❒ other

Are you currently a student, and if so, where?____

❒ Full-time ❒ Part-time________________

Advance Directive/Living Will: Do you have an Advance directive? ❒ Yes ❒ No (If so, we would like a copy)

If not, are you interested in information about developing one? ❒ Yes ❒ No

Living situation: Are you now or have you recently been homeless? ....❒ yes ❒ no

If not, do you currently live in an apartment? ❒ yes ❒ no house?....❒ yes ❒ no other?......❒ yes ❒ no

Do you have the following where you live? Toilet.................❒ yes ❒ no Stove/place to cook....❒ yes ❒ no

Electricity...........❒ yes ❒ no Tub/shower........ ❒ yes ❒ no Refrigerator...............❒ yes ❒ no

Hot/cold water... ❒ yes ❒ no Phone...............❒ yes ❒ no

Do you feel your current housing is adequate?...❒ yes ❒ no

Do you feel your home is safe/do you feel safe there? ....❒ yes ❒ no

Do you have smoke detectors? .... ❒ yes ❒ no

Guns in House:

Are there any weapons in your house? ....❒ yes ❒ no

If there are weapons in the house, are they: ❒ Loaded ❒ Kept locked ❒ Accessible to children

If there are weapons in the house, has everyone in the home been trained in firearm safety? ....❒ yes ❒ no

Family/Companions

Do you live alone?.. ❒ yes ❒ no

If you live with others (How many? __________________), is it crowded? .... ❒ yes ❒ no

Who do you live with: ____

Do you have any children?.. ❒ yes ❒ no

If so, please list: Full Name Age Full Name Age

__________________________________ ________ __________________________________ ________

__________________________________ ________ __________________________________ ________

Do any of your children or your partner's children live with someone else? .... ❒ yes ❒ no

If Yes, please explain: ____

Habits (please indicate if you have ever used and how much you use now):

Caffeine: coffee, tea, soda .... ❒ yes ❒ no

How many cups per day of: coffee? _____ tea? _____ soda? _____

Do you get a headache or other symptoms if you skip for a day? ❒ yes ❒ no

Tobacco:

Are you exposed to second hand smoke -- at home?......❒ yes ❒ no at work? ❒ yes ❒ no

Do you smoke cigarettes now? .... ❒ yes ❒ no

in the past? .... ❒ yes ❒ no

If so, how many packs per day?______ For how many years?______ How old were you when you started?__________

Do you use chewing tobacco, snuff, cigars, a pipe, or other forms of tobacco? .... ❒ yes ❒ no

in the past? .... ❒ yes ❒ no

If you currently smoke or chew tobacco, have you ever quit before?.. ❒ yes ❒ no

If yes, for how long? _______ What helped you quit?____

Would you like help in quitting tobacco now?.. ❒ yes ❒ no

Alcohol: How often do you drink an alcoholic beverage? *(1 drink = 5 oz wine, 12 oz beer, 1.5 oz spirits)*

Drinks per day_____ Drinks per week_____ How many drinks does it take to make you feel "high"?_____

If you drink, have you ever felt the need to cut down your drinking?.. ❒ yes ❒ no

felt annoyed by criticism of your drinking?.. ❒ yes ❒ no

had guilty feelings about your drinking? .... ❒ yes ❒ no

taken a morning "eye-opener"? .... ❒ yes ❒ no

When was your last drink? ____

Did you ever drink heavily in the past? .... ❒ yes ❒ no

Have you ever been unable to remember what you did during a drinking episode? .... ❒ yes ❒ no

Do you get into arguments or physical fights when you have been drinking?.. ❒ yes ❒ no

Have you ever been arrested or hospitalized because of drinking?.. ❒ yes ❒ no

Other: Do you or have you ever used any other recreational **drugs**? .... ❒ yes ❒ no

❒ marijuana ❒ crack/cocaine ❒ crank/methamphetamines

❒ heroin ❒ downers ❒ MDMA ❒ other ______________________

Have you ever used drugs through a needle?.. ❒ yes ❒ no

If you use drugs and/or alcohol, are you interested in quitting? .... ❒ yes ❒ no

Have you tried to quit? .... ❒ yes ❒ no

If you quit in the past, how long ago, what helped?____

Are you concerned about the drinking/drug use of any other members of your family? .... ❒ yes ❒ no

Other toxic exposures: (current or in the past)

Do you handle or have exposure to chemicals? (examples: glue, paint, bleach, ammonia, pesticides, fertilizers, Cleaning solvents, etc.)?

Past	Current	**Exposures**	Past	Current	
		Mold in bathroom			Mold in cellar, crawlspace, or basement
		Damp cellar or had water in basement			Heavily wooded or damp surroundings
		Pest extermination – inside			Well water
		Pest extermination – outside			Old or crumbling paint (when was house built?_____)
		Chemical use at work or with hobbies			New carpet or other remodeling
		Farm close to house (non-organic)			Feather or down bedding
		Power plant or lines close to house			Landfill/dump
		Industrial plant close to house			Gas or propane stove or heating

Safety: Do you ever ride in a car without wearing a seat belt? .... ❐ yes ❐ no
Do you use helmets every time when riding bicycles/motorcycles? .... ❐ yes ❐ no
Diet:
Do you follow a special diet (❐ vegetarian, ❐ vegan, ❐ low salt, ❐ low fat, ❐ diabetic, ❐ Other).................................. ❐ yes ❐ no

Please describe:____

How many times a week do you eat red meat? ____________________________
How many meals do you eat out every week? ❐ 0-1 ❐ 2-3 ❐ 4-5 ❐ more than 5
How many servings of fruit or vegetables do you eat every day ? ❐ 0-1 ❐ 2-3 ❐ 4-5 ❐ more than 5
Has your weight ever been a problem for you? .... ❐ yes ❐ no
Have you had weight fluctuations of more than 10 lb? .... ❐ yes ❐ no
What methods have you used to lose/gain weight? ____

____

Please list what you ate and drank yesterday, with approximate amounts: *(if that was not a typical day, list your last usual day)*

Breakfast	Lunch	Dinner	Snacks

Do you do your grocery shopping and food preparation? ❐ yes ❐ no If not, who does this:______________________________
Check all the factors that apply to your current lifestyle and eating habits:

- ❐ Fast eater
- ❐ Late night eating
- ❐ Eat more than 50% of meals away from home
- ❐ Do not plan meals or menus
- ❐ Eat because I have to
- ❐ Eat too much under stress
- ❐ Confused about nutrition advice
- ❐ Significant other/family members don't like healthy foods
- ❐ Significant other or family members have special dietary needs or food preferences
- ❐ Erratic eating pattern
- ❐ Dislike healthy food
- ❐ Travel frequently
- ❐ Poor snack choices
- ❐ Have a negative relationship to food
- ❐ Eat too little under stress
- ❐ Emotional eater (eat when sad, lonely, depressed, bored)
- ❐ Eat too much
- ❐ Time constraints
- ❐ Reliance on convenience items
- ❐ Love to eat
- ❐ Struggle with eating issues
- ❐ Don't care to cook

The most important thing I would like to change about how I eat to improve my health is: ___________________________________

How much water or uncaffeinated, unsweetened tea do you drink daily? _________________
Is your water generally: ❐ Well ❐ Tap ❐ Bottled
❐ Filtered ❐ Unfiltered

Exercise: Current Exercise program *(List type of activity, number of sessions/week, and duration)*

Activity	**Type**	**Frequency per week**	**Duration in Minutes**
Stretching			
Cardio/Aerobics, Zumba			
Strength (Resistance/weights)			
Other (Yoga, Pilates, Tai chi/ Qi Gong, etc.)			
Sports or leisure activities (golf, tennis, hiking, etc.)			

Rate your level of motivation for including exercise in your life: ❐ low ❐ medium ❐ high

List problems that limit activity: ____

Do you feel unusually fatigued or ill after exercise? ❐ no ❐ yes – please describe ____________________________________

Do you usually sweat when exercising? ❐ no ❐ yes

Sexual History:

Have you had sex in the last month?........ ❒ yes ❒ no
3 months?........ ❒ yes ❒ no
1 year?........ ❒ yes ❒ no
Are you satisfied with your sex life? .... ❒ yes ❒ no
Do you have or have you ever had sex with:........ ❒ men ❒ women ❒ both
How many people have you had sex with in the last year?........ ❒1 ❒ 2-3 ❒ more than 3
" " in your lifetime? ___________________
What do you use for birth control/safe(r) sex? ___________________
Do you want to discuss safe sex, AIDS, or other sexual issues with the doctor? .... ❒ yes ❒ no
Has anyone ever sexually abused or raped you as a child or an adult?........ ❒ yes ❒ no
If so, are you comfortable describing the event(s) to your provider? .... ❒ yes ❒ no
If so, have you had some counseling or other help with this? .... ❒ yes ❒ no
Do you feel this still affects you?........ ❒ yes ❒ no

Stress:

Are there currently any major stressors in your life? .... ❒ yes ❒ no
If so, what are they?___________________

____
Have you experienced major losses in your life?........ ❒ yes ❒ no

If so, what sort?___________________
Do you feel your life has meaning and purpose? .... ❒ yes ❒ no
Are you currently providing care for a disabled or elderly family member? .... ❒ yes ❒ no
Do you have concerns about your children or your relationship with them?........ ❒ yes ❒ no
Are you afraid of your own temper or that of anyone else in your family?........ ❒ yes ❒ no
Do you have problems with getting angry frequently or at little things? .... ❒ yes ❒ no
Do you sometimes feel out of control? .... ❒ yes ❒ no
Do you sometimes feel you are no good or you can't do anything right?........ ❒ yes ❒ no
Have you ever thought about or tried to commit suicide?........ ❒ yes ❒ no
Have you or anyone on your block been shot or mugged in the last year? .... ❒ yes ❒ no
Is there any history of violence in your family?........ ❒ yes ❒ no
Has anyone close to you ever physically hit you or hurt you?........ ❒ yes ❒ no
Do you feel unsafe in your current relationship?......... ❒ yes ❒ no
Is there a partner from a previous relationship who is making you feel unsafe now?........ ❒ yes ❒ no

Social Support:

Does someone you live with have serious health or emotional problems? .... ❒ yes ❒ no
Do you frequently feel isolated or alone?........ ❒ yes ❒ no
Do you feel people take advantage of you or try to control you?........ ❒ yes ❒ no
How do you deal with conflict in your family?___________________

____
Are you dissatisfied with the way your family communicates or expresses affection?........ ❒ yes ❒ no
Who provides you with emotional support(family, close friend, religious advisor, other)? ___________________

____

Pets: Do you have any pets or companion animals?........ ❒ yes ❒ no

Name	Species	Name	Species
____________	____________	____________	____________
____________	____________	____________	____________

Spiritual Life/Meditation/Relaxation:

Do you practice meditation or relaxation techniques? ❒ no ❒ yes. How often?___________________
Check all that apply ❒ Yoga ❒ Mindfulness ❒ Imagery ❒ Breathing ❒ Tai chi ❒ Prayer ❒ Other:___________________
Is there a particular spiritual practice or belief system that is meaningful to you? .... ❒ yes ❒ no
Name or Description (optional): ___________________
Do you practice this singly and/or with a group?........ ❒ alone ❒ yes, with a group
Would you be willing to have us contact your spiritual advisor and/or other support people in the event you became very ill? .... ❒ yes ❒ no
Contact person: ___________________ Phone: (______) ______ - __________
Did you/your family follow a particular spiritual practice when you were a child?........ ❒ yes ❒ no
If so, name or description: ___________________

Sleep/Rest:
Average number of hours you sleep per night: ❒ <6 ❒ 6-8 ❒ 8-10 ❒ >10
Do you have trouble falling asleep? .... ❒ yes ❒ no
Do you have trouble staying asleep? .... ❒ yes ❒ no
Do you feel rested upon awakening? .... ❒ yes ❒ no
Do you snore? .... ❒ yes ❒ no

Hobbies, other activities (church groups, sports, musical instruments, etc.): ____________________________________

____

Assistive Devices:
Do you use: ❒ glasses or contact lens ❒dentures, crowns, or bridges ❒any assistive devices (walker, cane, grasper, etc.)

Current symptoms: please mark any symptoms you have been noticing, and write details next to it or below.

Constitutional: ❒ fatigue ❒ fever ❒ chills ❒ weight loss or weight gain ❒ ________________

Mouth: ❒ Tooth pain ❒ Bleeding Gums ❒ Gingivitis ❒ bad breath ❒ Problems with Chewing ❒ Canker sores ❒ Dry mouth
Do you floss regularly? ❒ yes ❒ no Do you have a dentist? ❒ yes ❒ no

Head, neck: ❒ double vision ❒ blurred vision ❒ dry eyes ❒ eye pain ❒ ear discharge ❒ ear pain ❒ ringing in the ears
❒ nasal/sinus congestion ❒ nosebleeds ❒ postnasal drip ❒ sore throat ❒ hoarseness ❒ abnormal smell/taste ❒ ________________

Breathing: ❒ shortness of breath ❒ cough ❒ wheezing ❒ ________________

Heart/Circulation: ❒ chest pain ❒ palpitations(racing or irregular heartbeat) ❒ swelling in ankles ❒ leg pain with walking
❒ dizziness/lightheadedness ❒ fainting ❒ ____________

Breast: ❒ breast tenderness ❒ discharge from nipple ❒ breast mass ❒skin changes on the breast ❒ ________________

Eating: ❒ Binge eating ❒ Bulimia ❒ Can't gain weight ❒ Can't lose weight ❒ Poor appetite
❒ Cravings (for ❒ salt ❒ carbohydrates ❒ sweets ❒ chocolate ❒ other__________- including clay, dirt, and other strange things)

Digestive: ❒ loss of appetite ❒ abdominal pain ❒ difficulty swallowing ❒ nausea ❒ vomiting ❒ constipation ❒ diarrhea ❒ heartburn
❒ blood in stools ❒ mucus in stools ❒ Excessive gas ❒ Recent changes in bowel habits ❒ ________________
Do you feel like you digest your food well? . . . . ❒ yes ❒ no
Do you feel bloated after meals? . . . . ❒ yes ❒ no
How often do you have a bowel movement: ______times per day _____days per week
Are your bowel movements: ❒ Hard ❒ Formed but soft ❒ Soft and unformed ❒ Liquid ❒ Varies

Kidney/Bladder: ❒ Increased frequency of urination ❒ burning or pain on urination ❒ loss of control of urine(accidents)
❒ incomplete emptying of bladder ❒ getting up more than twice a night to urinate ❒ kidney stone ❒ ________________

Sexual problems: ❒ lack of interest in sex ❒ pain with sex ❒ loss of lubrication ❒ lack of climax

Female: ❒ vaginal discharge ❒ problem with periods: ❒ heavy periods ❒ irregular bleeding ❒ severe cramps ❒ PMS
❒ genital sores ❒ ________________

Male: ❒ problems with erections ❒ discharge from penis ❒ lumps in testicles ❒ genital sores ❒ _____________

Lymph/Blood: ❒ Swollen glands ❒ bruises easily ❒ ________________

Muscle/Bones: ❒ neck pain ❒ joint pain ❒ back pain ❒ muscle pain ❒ leg cramps with exercise or at night ❒ muscle twitches
❒ Muscle spasm ❒ joint redness or swelling ❒ limits on range of motion ❒ ________________

Skin/Hair/Nails: ❒ acne ❒ athlete's foot ❒ bumps on back of upper arm ❒ eczema ❒ itching ❒ changing moles or sores ❒ dry skin
❒ brittle nails ❒ ridges in nails ❒ hair loss ❒ change in pigment ❒ ________________

Nerves: ❒ Headache ❒ dizziness ❒ weakness ❒ numbness or tingling ❒ tremor/shaking ❒ poor coordination ❒ seizure ❒ memory problems ❒ speech problems ❒ ________________

Psychiatric: ❒ difficulty sleeping ❒ mood swings ❒ feeling anxious ❒ feeling depressed ❒ Suicidal thoughts ❒ bad temper
❒ Hallucinations ❒ ________________

Hormone: ❒ hungry all the time ❒ thirsty all the time ❒ feeling unusually cold or hot ❒ Menopause symptoms ❒ ________________

Allergic, immunologic: ❒ hives ❒ allergies in nose or eyes ❒ ________________

Are there other issues that you would like to discuss with your provider? Please describe: ___________________

____

____

Readiness assessment *Rate on a scale of 5 (very willing) to 1(not willing):*
In order to improve your health, how willing are you to:

Keep a record of everything you eat each day:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Significantly modify your diet:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Take several supplements or medications daily:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Modify your lifestyle (e.g. work demands, sleep habits):	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Practice a relaxation technique:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Engage in regular exercise:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1

Comments: ____

How confident are you of your ability to organize and follow through on the above health-related activities?: ❒ 5 ❒ 4 ❒ 3 ❒ 2 ❒ 1

Comments: (If you are not willing or not confident, what are the barriers to fully engaging in these activities?)

____

____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

❒ Very supportive ❒ Neutral ❒ Unsupportive

How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from our staff would be helpful to you as you implement your personal health program? ❒ Very frequent contact ❒ Occasional contact ❒ I'll work on it on my own

Comments:

____

Coordination with other providers involved in your care:

Do you see other health care providers than your primary doctor here (such as a therapist, other physicians, chiropractors, accupuncturists, naturopaths, herbalists, etc.) on a regular basis? . . . . ❒ yes ❒ no

Who do you see? Name Profession

_____________________________ ___________________________________

_____________________________ ___________________________________

_____________________________ ___________________________________

_____________________________ ___________________________________

Would you like your provider at our clinic to consult with/coordinate your care with your other provider(s)? . . . . ❒ yes ❒ no

Full Circle Patient Portal Informed Consent

Name: ____ DOB: ____________________

The Patient Portal is a secure web-based system which allows you to communicate with our office and access portions of your medical record. The Patient Portal will require a username and a password.

The portal is available at any time for non-urgent issues and allows you to bypass the phone system, communicating with our office at your convenience. The portal allows you to:

- View and print selected health information and medication records
- Request or cancel appointments
- View messages and educational materials from your provider
- Pose questions to your provider
- View limited lab test results
- Pay bills with our practice

You will be notified by e-mail if you have a message or results to review on the portal.

By using the Patient Portal, you agree to the following Terms & Conditions:

- Take steps to keep portal communications private and confidential including:
- Update contact information online as soon as it changes, including your e-mail address
- Keep your username and password safe and private
- Avoid communicating per personal e-mails

When posing questions to the practice:

- Use is limited to NON-URGENT communication and requests
- Communication following an appointment to clarify recommendations will be provided at no charge
- Please allow up to 24 hours or the next business day to respond to communications; the portal may not be checked on the weekend
- Virtual visits may be available for some new complaints, at a charge, but if the matter is urgent, a phone call to the office to notify us of your request is recommended

The following agreements and procedures relate to online communications:

- Copies of all medically important Patient Portal communications will be saved in your electronic medical record
- Patient Portal communications will be used only for limited purposes and cannot be used for emergencies, highly sensitive medical information, or time sensitive matters

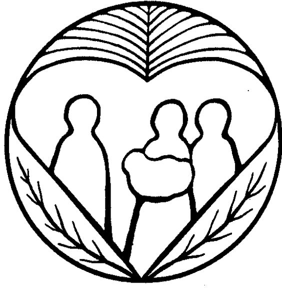
Risks of using Online Patient Portal Communications

All medical communications carry some level of risk. While the likelihood of risks associated with the Portal is low, it is possible for online communications to be forwarded, intercepted, or even changed without your knowledge. We use a secure network for the patient portal to minimize this risk.

Patient Acknowledgement and Agreement

By using the Patient Portal you acknowledge that you have read and fully understand the Terms & Conditions as described. You understand the procedures and risks associated with online communications with your healthcare team and you consent to the conditions described. If you decide you do not want to use the portal, please notify us to deactivate your account. If you have any portal problems, please notify us.

Signature ____ Date_______________________



Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

Medical Records Release

I request the release of information regarding ____
Patient's Name

Date of Birth:___________________

FROM:
Provider/Group name::____

Address:____

City/State/Zip____

TO:
Provider/Group/Other: Full Circle Center for Integrative Medicine

Address: 4641 Valley East Blvd #2

City/State/Zip: Arcata CA 95521

I specifically need the following information released (INITIAL EACH ITEM):

___ All information regarding the assessment, diagnosis, and treatment of______________________
___ All information regarding the care provided from _________ until __________
Date Date

Unless "No is written in and initialed, the records will include the following:
Alcohol and drug use/abuse __ _____ Mental Health Information __ _____ HIV status __ ____
No Initials No Initials No Initials

___ Other ____

____

Lab Results ______ TB results ______ EKG report ______

Immunizations ______ X-ray results ______ Consults ______

The person receiving this information may only use it for the following purposes:
__ Assessment & Evaluation __ Legal Proceedings of Legal Advice __ Employment
__ Health Insurance Enrollment __ School or Educational Needs __ Personal Use
__Aid or Entitlement __Other (Specify) ____________________

This consent shall remain valid for one year from date of signature unless otherwise specified.

___________ ____
Date Patient, Parent, Conservator, or Guardian (Circle one)

___________ ____
Date Witness Signature

The patient has the right to receive a copy of this authorization.