Integrative Family Medicine of Asheville, PLLC

Comprehensive • Affordable • Primary & Urgent Care

Thank you for scheduling your Annual Physical with Integrative Family Medicine.

Please complete this brief intake form so we can learn of any changes in your health history since your last annual exam. The more honest and complete you can be with your answers, the better we will be able to support you. Please be sure to fill in your contact information as well.

If for any reason you need to cancel your appointment, we ask that you give us 24 hours notice. We reserve the right to charge you for your appointment if less than 24 hours notice is given.

Full payment is due at the time of service

Your comprehensive annual physical exam is provided at no cost when renewing your membership contract for 12 months. The non-renewal/month-to-month cost is $180.

For Medicare and Medicaid Patients Only:

The services we provide are currently not reimbursable under Medicare or Medicaid. At this time, you may not submit our invoices for reimbursement. However, referrals to specialists, hospitals, and for procedures such as x-rays or MRI would still be covered by Medicare or Medicaid.

For any questions regarding your appointment or these forms, please call us at 828-575-9600 or inquire with our front desk staff. We look forward to seeing you again.

Controlled Substance Policy for Integrative Family Medicine of Asheville

At Integrative Family Medicine our goal is to explore natural and holistic methods for treating medical problems prior to prescribing controlled substances. We will not prescribe controlled substances for patients on their first visit, and we will only prescribe them for established patients after the third visit. If necessary, we will prescribe controlled substances only as part of a holistic treatment plan.

We require a controlled substance agreement that outlines how we prescribe these medications and establishes an understanding that you may only receive controlled substances from one provider or clinic. If a patient is found to be non-compliant with this agreement, we hold the right to refuse any future care at Integrative Family Medicine.

- We will not refill controlled substances from other physicians under any circumstances.
- We will not refill medications that have been lost or stolen until you are due for your next refill.
- We require that you use one pharmacy to obtain all of your controlled substances.
- We reserve the right to require random drug tests if we have concerns about controlled substance use.
- We may discontinue treatment if you are found to use illegal drugs such as heroin, cocaine, or amphetamines.

If you have a condition that will require chronic narcotic prescriptions we recommend that you establish care with a pain management center. We would be happy to coordinate our services with such a center. We also recommend a variety of therapies such as counseling, acupuncture, yoga, qigong, meditation, nutrition, and massage that work well for chronic conditions. We may be able to help you decrease or eliminate your need for pain medications.

We do not have any narcotic medication on the premises of Integrative Family Medicine.

Signature:_____Date _____

PLEASE PRINT AND COMPLETE IN FULL

***Please fill in all the information below, even if you think we have it listed on file correctly.**

Date_____

Patient's Legal Name:

_____ Nickname_____
Last First M

Is Patient enrolled in Medicare or Medicaid?_____

Mailing Address_____ Zip Code_____

Cell Phone_____ Home Phone _____ Work Phone_____

Email Address for Self (or Parent/Guardian, if pt is a minor):_____

If Patient is a minor, Parent/Guardians:

#1 Name _____Relationship _____ Occupation _____

#2 Name _____ Relationship _____ Occupation _____

Name & Relationship of Primary Emergency Contact_____

Phone number of Primary Emergency Contact_____

Email Address for Minor, if applicable:_____

Preferred Email from above for all communications (circle one): Parent/Guardian's Minor's

Health History

What are your goals for this visit?

_____
_____
_____

Please prioritize your most important health concerns today:

	Concern	Onset	Frequency	Severity
	Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Please advise us of any milestones or goals reached over this past year, any challenges, and any new barriers to good health:

_____
_____
_____

Any dietary changes? Please describe:

_____

Any exercise changes? Please describe

_____

Any occupational changes? Please describe

_____

Any changes in your family's health history? Any new diagnoses?

_____

Any new drug allergies, hospitalizations, or surgeries?

_____
_____
_____

Any updated vaccinations given?

_____

How is your energy level?

_____

Have there been any changes in your personal health history? (Depression, Ear Problems, etc.)

_____

_____

THIS PAGE FOR ADULTS & TEENS ONLY

Substances

	Amount per Day	Amount per Week	Never Used	Past History of Use
Cigarettes	_____	_____	_____	_____
Cigars/Pipe/Chewing	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Other Drugs/Substances	_____	_____	_____	_____

Preventative Screenings

Date of last Colonoscopy_____

Date of last Pap Exam (Women) _____ History of abnormal Pap Exam? _____

Date of last Mammogram (Women) _____ History of abnormal Mammogram?_____

Date of last Prostate Exam (Men) _____ History of abnormal Prostate Exam?_____

Date of last Dexa Scan (Bone Density Test) _____

Sexual and Relationship History (If Applicable)

Are you currently in a relationship? _____ yes _____ no Is it monogamous? _____ yes _____ no

Are you happy with your current sex life? _____ yes _____ no

Do you feel safe in your current relationship? _____ yes _____ no

Please describe the method of contraception you are currently using:_____

Experiences with current method:_____

Women Only

If applicable: **First day of most recent menstrual period_____ # of days between periods_____**

Do you have (please circle): Painful Periods Missed Periods Spotting Between Periods Vaginal Bleeding

Any unusual discharge, discomfort, infection, or recurring vaginal infections, and if so, what kind?

_____

***If you have gone through menopause*: Have you had any post menopausal bleeding? _____**

Number of: Pregnancies_____ Live Births_____ Abortions_____ Miscarriages_____

Have you experienced complications during pregnancy/delivery/other problems? _____

PRESCRIPTION MEDICATIONS - Please list on the table below ALL prescription medication you take or use.

Name of Medication (Brand name) and **Strength**	**How were you told to take this medication?**	**How often do you take/use this medication?**	**How much do you take/use for each dose?**	**When did you begin taking this medication?**	**Condition treated with this medication**	**When did you stop taking this medication?**	**Why did you stop taking this medication?**

NON-PRESCRIPTION MEDICATIONS AND SUPPLEMENTS CURRENTLY OR RECENTLY TAKEN
(Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products)

Brand name of Product and list of Ingredients	**Dosage**	**Amount per dose**	**Frequency**	**When did you begin?**	**Reason for this supplement**	**When did you stop?**	**Why did you stop taking this product?**

*Please use the back of this sheet as needed

Other Providers on Your Health/Wellness Team

Please list the name and title of all other providers currently supporting you (ie. acupuncturist, physical therapist, specialists, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Any additional notes: