



HealthMotivate Care

**Dr. Robert Spady
Dr. Kelsey Cherepuschak
Laurie Edinger, ARNP**

YOUR APPOINTMENT IS SCHEDULED ON: _____

MOSCOW

Moscow Professional Center
619 S. Washington Suite 203
Moscow, ID 83843

Phone (208) 892-1346
Fax (208) 892-8306

PULLMAN

805 SE Clearwater Drive
Pullman, WA 99163

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:

- Insurance card.
- Copay as required by your insurance.
(If you do not have insurance, the payment is expected in full at time of visit.) A discount will apply.
- Medications, vitamins and/or supplements you are currently taking.

PLEASE NOTE: Included in this packet is a records release form. Please fill out and have this form sent to previous physician's office **PRIOR** to your appointment with us. We will be happy to fax it if you are unable to send it yourself. *It is important to our doctors to give you the best care possible, and they want to have a chart filled out and ready when you come in.*

(If this packet is not completed in advance, please arrive 30-45 minutes early to complete it before your scheduled appointment time.)

WE LOOK FORWARD TO MEETING YOU!



HealthMotivate Care

Patient Name: _____ Age: _____ Date of Birth: _____

Marital Status: _____ Social Security #: _____ Male Female

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: () _____ May we contact you at work? Yes No

Cell Phone: () _____

Work Phone: () _____ Employer: _____

Email: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Pharmacy (please specify location if more than one): _____

How did you hear about us? Please circle: Internet Phone book Friend or Family Other: _____

How would you like to be contacted? Please circle: Home Phone Cell Phone Work Phone Email Letter

Which race do you feel best describes you? Please circle: White Black or African American American Indian or Alaska Native

Native Hawaiian or other Pacific Islands Asian Prefer not to disclose Other: _____

Do you consider yourself Hispanic? Please circle: Yes No Not sure Prefer not to disclose

If not the patient, who is the Guardian or Responsible Party?:

Name: _____ Relationship to Patient: _____

Social Security # _____ Address: _____

City/State: _____ Zip: _____ Home Phone: () _____

Employer: _____ Address: _____

City/State: _____ Zip: _____ Work Phone: () _____

To the best of my knowledge, the information above is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

MEDICARE ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to HealthMotivate Care for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents, any information needed to determine these benefits, or the benefits payable for related services.

SIGNATURE: _____ **DATE:** _____



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By signing this form, I acknowledge that I have received a copy of HealthMotivate Care Privacy Practices Notice.

Patient signature (or legal representative)

Date

Legal representative's relationship to patient

A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices. The following identifies the efforts made and the reason the acknowledgment was not obtained.

Signature of HealthMotivate Care Member

Date

Reason

By signing this form below I am acknowledging having received HealthMotivate Care Office Policy/Patient Information form.

Patient signature (or legal representative)

Date

Legal representative's relationship to patient



HealthMotive Care

Authorization for Disclosure of Protected Health Information

I _____, give permission to HealthMotive Care, to share and discuss protected medical information regarding my care to:

	NAME	RELATIONSHIP	LAST FOUR DIGITS OF THEIR SS# OR THEIR MOTHER'S MAIDEN NAME
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Information to be disclosed (check all that apply)

- All information
- Exception(s): _____

This authorization is valid indefinitely unless notified by patient. You may revoke this authorization at any time.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

HealthMotivate Care Office Policies / Patient Information

The purpose of this form is to inform our patients of the policies of HealthMotivate and to give them helpful information that will enhance our ability to better serve each patient.

- For refills, contact your pharmacy and allow 3-4 business days for processing. Additionally, benzodiazepines and chronic narcotics will not be filled after hours or on weekends.
- We require that patients notify our office at least 24 hours in advance of all appointments requiring cancellation or rescheduling. We allow one grace appointment per year, but any subsequent missed or changed visits may result in a \$30.00 fee.
- Co-pays are, as always, due at the time of service. Any co-pay not received at the time of visit will be subject to a \$5.00 service fee.
- HealthMotivate Care requires all of its private paying patients to pay in full at time of visit. We offer a 15% discount for this payment.
- All patients taking chronic narcotics are required to sign a medication agreement contract and will be subject to random urine testing to insure compliance. Additionally, these patients must agree to use only one pharmacy for all refills of their controlled medications.
- We will not be scheduling any appointments for new Worker's Compensation or Labor and Industries claims (L&I) or Idaho Medicaid.
- Patients wishing to be seen post a motor vehicle accident (MVA) must pay in full for this appointment at time of service. We will assist the patient with documenting their claim, but patients will be responsible for reimbursement on their own.

HIPAA Notice of Privacy Practices

Effective date: April 14, 2003

HealthMotivate Care

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected health information*, or *PHI*). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligation concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

HealthMotivate Care Compliance Officer (208) 892-1346, 619 S. Washington, Suite 203, Moscow, ID 83843.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors, nurses and receptionists – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, other physicians and providers with whom we may have agreements with to occasionally cover our practice.

2. IDAHO HEALTH DATA EXCHANGE. This office has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not want to participate in the IHDE and you do not want to have your health care information shared with other medical providers involved in your care, you can opt out of the participation. To opt out, you must complete and sign the IHDE "Request to Restrict Disclosure of Health Information" form and mail or fax it to IHDE. You will receive a letter of confirmation upon completion of your request. This will restrict your information from being released through the exchange only (you will need to contact direct any facility you wish to also restrict your information with). The IHDE form is available at the front desk. If you do not complete this form, we may share your protected health information with other participating healthcare providers involved in your care through the IHDE. This is a secure statewide internet-based health information exchange, with the goal of improving the quality and coordination of health care in Idaho.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information

HealthMotivate Care
Clinic Shared/Office Forms/New Patient Packet/HIPAA Notice of Privacy Practices

for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Medical and Nursing Education. Unless you object, our practice may use and disclose your PHI to teach medical students and nursing students who see patients in our office and in the community under our guidance.

8. Volunteer Services. Unless you object, our practice may use and disclose your PHI to inform you of volunteer services available through our office. Volunteers may assist you with services offered in, or coordinated through our office, and may be given access to your PHI as needed to accomplish those services. Our practice may use and disclose your PHI with volunteers who will be involved in your care, or who will assist in taking care of you.

9. Counselors, Clergy and Community Resources. Unless you object, our practice may use and disclose your PHI to inform you of counseling, clergy related benefits or community services that may interest you. Our practice may release your PHI to counselors, clergy members or other community resources who will be involved in your care, or who will assist in taking care of you.

10. Release of information to family/friends. Unless you object, our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

11. Fundraising Activities. Unless you object, our practice may use or disclose your PHI to raise funds for the community and global outreach of our practice. If you do not wish to be contacted for fundraising purposes, please contact Total Health Physician Group Compliance Officer.

12. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

If you have any questions regarding this notice or if you have objections to our health information privacy policies, please contact HealthMotivate Care Compliance Officer, Phone (208) 892-1346, 619 S. Washington, Suite 203, Moscow, ID 83843.

D. Use and disclosure of your PHI in certain special circumstances: The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for

example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you or the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law-enforcement official:

- Regulating a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location or the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board waives the authorization requirement following a special process to ensure that the confidentiality of your PHI is protected.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law-enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to HealthMotivate Care Compliance Officer, 619 S. Washington, Suite 203, Moscow, ID 83843, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.

In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to HealthMotivate Care Officer, 619 S. Washington, Suite 203, Moscow, ID 83843.

Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: HealthMotivate Care Compliance Officer, 619 S. Washington, Suite 203, Moscow, ID 83843 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstance; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to HealthMotivate Care Compliance Officer, 619 S. Washington, Suite 203, Moscow, ID 83843. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion:

- a) Accurate and complete,
- b) Not part of the PHI kept by or for the practice,
- c) Not part of the PHI which you would be permitted to inspect and copy; or
- d) Not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: HealthMotivate Care Compliance Officer, 619 S. Washington, Suite 203, Moscow, ID 83843. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact HealthMotivate Care Compliance Officer, 619 S. Washington, Suite 203, Moscow, ID 83843.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: HealthMotivate Care Compliance Officer, (208) 892-1346, 619 S. Washington, Suite 203, Moscow, ID 83843. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

9. Waiver of Rights. Our practice may not require individuals to waive their rights as a condition of the provision of treatment.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact HealthMotivate Care Compliance Officer, (208) 892-1346, 619 S. Washington, Suite 203, Moscow, ID 83843.

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Medical Records Release

Patient Name _____ Date of Birth _____

Information to be released from:

Facility or Provider _____

Address _____ Phone Number (_____) _____

City _____ State _____ Zip code _____ Fax Number (_____) _____

I request and authorize the facility or provider named above to release health care information of the patient named above to:

Name of designated recipient _____

Address _____ Phone Number (_____) _____

City _____ State _____ Zip code _____ Fax Number (_____) _____

Information to be released:

- The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
- All medical records
- Electronic records
- Specific information (Please specify): _____

For the following purpose: _____

The following items must be initialed to be included in the use and/or disclosure of other health information:

- _____ HIV/AIDS related information and/or records
- _____ Mental health information and/or records
- _____ Genetic testing information and/or records
- _____ Drug/alcohol diagnosis, treatment or referral information (federal regulations require a description of how much and what kind of information is to be disclosed) Describe: _____

Patient Authorization:

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

Signature of Patient or legal representative

Date

Print Patient's Name

Print Name of Legal Rep/relationship to patient

PERSONAL HEALTH HISTORY QUESTIONNAIRE DATE: _____

Patient Name: _____	Date Of Birth _____	Age: _____
Occupation: _____	Employer: _____	
With Whom Do You Live? _____	On Whom Do You Depend On For Transportation? _____	
Partner Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/>		
Religion: _____	Level of Education Completed: _____	Number of Children: _____

FAMILY HISTORY

If any blood relative has suffered from any of the following, please check and indicate which relative in the space provided:

Please List ALL Blood Relatives - GP= Grandparent, S= Sibling, M= Mother, F= Father

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Clotting Disorders _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Stomach Problems _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Dementia _____ | <input type="checkbox"/> Mental Illness _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Migraine _____ | <input type="checkbox"/> Breast Cancer _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Colon Cancer _____ |
| | | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Other Cancer _____ |

If Mother Deceased, Age & Cause of Death: _____

If Father Deceased, Age & Cause of Death: _____

HOSPITAL ADMISSIONS	YEAR	ILLNESS/OPERATION	YEAR	ILLNESS/OPERATION
(Please Include Pregnancies & Past Illnesses)				

List Name & Dosage of All Medications That You Are Taking

Please Include: Prescriptions, Supplements, & Non-Prescription Drugs

1.	4.	7.
2.	5.	8.
3.	6.	9.

ALLERGIES If none, please check box: Please List All Known Allergies, Especially to Medicines or Anesthesia.

Please List The Month & Year Of Your Most Recent: Tests, Exams and Immunizations		
Advance Directive:	Power of Attorney:	POLST Form:
Eye Exam:	Stool Card:	Pneumonia Vaccine (65 yrs. and older):
Diabetic Foot Exam:	Colonoscopy:	Shingles Vaccine (60 yrs. and older):
Mammogram:	Cholesterol Screen:	Hepatitis Vaccine:
PAP Smear:	Tetanus Shot (every 10 years):	HPV:
Bone Density:	Flu Shot:	TB Skin Test:

List Health Care Providers That You See Currently (Or Have Seen) For Your Major Medical Problems

WHAT QUESTIONS MAY I ANSWER FOR YOU CONCERNING YOUR HEALTH?

PLEASE CHECK THE ITEMS BELOW THAT YOU HAVE NOW OR HAVE HAD IN THE PAST

HEENT	Present	Past
Wear Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Hearing/Seeing	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Blood Shot Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ringing In the Ears	<input type="checkbox"/>	<input type="checkbox"/>
Ear Wax Problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums/Sores Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Voice Change	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy Neck/Head	<input type="checkbox"/>	<input type="checkbox"/>

CV-RESP	Present	Past
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Leg Pain with Walking/Resting	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol/Triglyceride	<input type="checkbox"/>	<input type="checkbox"/>
Anemia (Low Blood Count)	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or Bruising Easily	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Racing, Pounding Heart	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Fingers Change Color & Hurt	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Laying Flat	<input type="checkbox"/>	<input type="checkbox"/>
Lung or Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/ Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Up Blood	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

GI	Present	Past
Chronic Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>
Bloody or Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Problem	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea/ Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Change in Stool Size/Shape	<input type="checkbox"/>	<input type="checkbox"/>

GU	Present	Past
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Leaking Urine/ Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Urination at Night > 1 Time	<input type="checkbox"/>	<input type="checkbox"/>
Pain or Blood on Urination	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>

MALES ONLY	YES	NO
Change in Stream	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Lumps on Testicles	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with Erections	<input type="checkbox"/>	<input type="checkbox"/>

NEURO-MUSCULAR	Present	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Passing Out/Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Coordination Problem	<input type="checkbox"/>	<input type="checkbox"/>
Tremors or Unsteadiness	<input type="checkbox"/>	<input type="checkbox"/>
Memory/Thinking Problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or Gout	<input type="checkbox"/>	<input type="checkbox"/>
Red/Swollen/Stiff Joints	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Back or Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Painful Joints/Muscle/Bones	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

SKIN	Present	Past
Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Rashes/Itching	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Moles Changing Size/Color	<input type="checkbox"/>	<input type="checkbox"/>
Dry or Oily Skin	<input type="checkbox"/>	<input type="checkbox"/>

METABOLIC	Present	Past
Weight Gain or Loss	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (High Blood Sugar)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or Anxious	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Loss of Hair	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Diet	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY	YES	NO
Age of First Menses		_____
First Day of Last Menses		_____
Menstrual Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Getting Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Breast Lump or Pain	<input type="checkbox"/>	<input type="checkbox"/>
Do You Do Self-Breast Exams	<input type="checkbox"/>	<input type="checkbox"/>
#Pregnancies _____ #Miscarriages _____		
#Abortions _____ #C-Sections _____		
Pregnancy Complications	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Changes	<input type="checkbox"/>	<input type="checkbox"/>
MENOPAUSE	YES	NO
Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes/ Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>

BOTH MALES AND FEMALES	YES	NO
Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Concerns	<input type="checkbox"/>	<input type="checkbox"/>
Partner Preference		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both		
Type of Birth Control Used (If Needed/Desired)		_____

ILLNESSES	Present	Past
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>

EMOTIONAL	YES	NO
Partner Relations Good	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy Employment	<input type="checkbox"/>	<input type="checkbox"/>
Unhappy or Depressed	<input type="checkbox"/>	<input type="checkbox"/>
Crying Spells	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thought/Intent	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Victim of Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>

Thank You for Your Time!

Name: _____

Spiritual History Section

Please answer the following questions:

1.- S= Sources of Strength (What gives you inner Strength and Support?)

2.- O=Outlook on religion and beliefs (What religion, faith group, or belief shapes you most?)

3.- U=Underlying life events (What significant issues or life events (gains or losses) do you want us To be aware of as we care for you?)

4.- L=Links to care(What religious practices or beliefs would you like us to consider as we care for You?)

Lifestyle Medicine Short Assessment Form



The following questions comprise the core metrics we propose using to capture readiness, willingness and confidence to change, as well as health behaviors that are aligned with the six pillars of lifestyle medicine. This assessment tool was adapted from the original Loma Linda University/American College of Lifestyle Medicine short form published in 2019 and updated in 2024.

Readiness to Change

On a scale of 0-10, with 0 being least and 10 being most, how important is it that you make lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10
 Not Ready Somewhat Ready Very Ready

On a scale of 0-10, with 0 being least and 10 being most, how confident are you to make lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10
 Not Confident Somewhat Confident Very Confident

Motivation

Please rank the top 3 areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).

- Avoidance of Risky Substances
- Nutrition
- Physical Activity
- Sleep
- Social Connectedness
- Stress Management

Nutrition: ACLM Diet Screener 9

This brief questionnaire will ask about your usual diet over the last 4 weeks. Please try to answer as accurately as possible – there are no right or wrong answers. Your best guess is better than leaving a blank. It's ok if something that you eat falls into more than one category.

Over the last 4 weeks, how often did you eat or drink the following items?

Fruit (Apples, bananas, oranges, melon, berries, or any other fruit)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day



Nutrition: ACLM Diet Screener 9

Vegetables (Cooked and raw leafy greens, tomatoes, carrots, potatoes, peas, or any other vegetables or dishes that are mostly made from vegetables)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Whole Grains (Oats, brown rice, whole grain bread or whole grain cereal, or any other 100% whole grain products)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Refined Grains or Refined Grain Products (Any items made from white flour or white rice, like bread, tortillas, baked goods or snacks, pasta, or other foods)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Packaged/Prepared, Restaurant, Takeout, or Fast Food Meals (Any store-bought dishes or meals, refrigerated or frozen, or any kind of ready-to-eat meals or dishes, take-out, or meals from a restaurant)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Sugary Foods and Beverages (Sweetened (sugar added) breakfast cereals, sweetened yogurts, candy, other desserts, or other foods with added sugar, or any sweetened beverages including soda/pop, sweetened tea or coffee drinks, energy drinks, etc.)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Salty Foods (Chips, crackers, or other salty snacks; canned soups, sauces, salad dressings, or other foods with added salt)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Fried Foods (Fried foods such as French fries, onion rings, fried chicken or other meat, fried potatoes, fry bread, tempura, or other fried foods)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Nutrition: ACLM Diet Screener 9

Which sources of protein do you eat frequently (at least a few times a week)?

Please select all that apply.

- Beef, pork, or lamb
- Lunchmeat, bacon, or sausage
- Poultry or poultry-based dishes
- Wild game (venison, elk)
- Nuts and seeds

- Fish or shellfish or seafood-based dishes
- Beans/legumes, or products made from them
- Dairy and dairy products
- Eggs or egg-based dishes

Physical Activity: Exercise Vital Sign¹

For an average week in the last 30 days, how many days per week did you engage in moderate to vigorous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?

_____ days

On those days that you engage in moderate to vigorous exercise, how many minutes, on average, do you exercise?

_____ minutes

During the past month, how many times per week did you do physical activities or exercises to strengthen your muscles?

_____ times per week

Sleep

Over the last 2 weeks, how many hours of sleep did you average in a 24-hour period?

Less than 4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9 or more hrs

Over the last 2 weeks, how often did you feel tired or have difficulty staying awake during routine tasks in the day?

Not at all	Several days	More than half the days	Nearly every day

Stress - PSS-4² (if not already present in electronic health record)

In the last month, how often have you felt

That you were unable to control the important things in your life?

Confident about your ability to handle your personal problems?

That things were going your way?

Difficulties were piling up so high that you could not overcome them?

Never	Almost never	Sometimes	Fairly often	Very often

Meaning and Connectedness

Over the last 2 weeks, how often have you felt like your life had purpose or meaning?

Not at all	Several days	More than half the days	Nearly every day

Over the last 2 weeks, how often have you felt connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)?

Not at all	Several days	More than half the days	Nearly every day

Substance Use

In the case that something in the electronic medical record already exists to assess for the following substances, we recommend you use those assessment tools.

Have you used NICOTINE (cigarettes, e-cigarettes/vaping, chewing tobacco, cigars) in the past year?

Yes No

If you marked "YES", how many (cigarettes, e-cigarettes/vaping, chewing tobacco, cigars) do you usually use a week?

per week

Are you currently using any over-the-counter or prescription nicotine replacement products?

Yes No

Are you interested in quitting?

Yes No

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your nicotine use?

0 1 2 3 4 5 6 7 8 9 10
Not Concerned Somewhat Concerned Very Concerned

Have you used ALCOHOL (12 oz beer, 5 oz wine, 1.5 oz liquor) in the past year?

Yes No

If you marked "YES", how much alcohol do you usually use a week?

per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your alcohol use?

0 1 2 3 4 5 6 7 8 9 10
Not Concerned Somewhat Concerned Very Concerned

Have you used MARIJUANA / THC / CBD in the past year?

Yes No

If you marked "YES", is this marijuana prescribed by a healthcare professional?

Yes No

If you marked "YES", how much marijuana do you usually use a week?

per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your marijuana use?

0 1 2 3 4 5 6 7 8 9 10
Not Concerned Somewhat Concerned Very Concerned



