Medicinal Life
114 W. Underwood St. Suite B, Orlando FL 32806
Tel: 407-412-6354 Email: patientinfo@medicinallife.com

Print Form

Patient Intake Form

Patient Information

Last Name | MI | First Name | Age | ☐ Male ☐ Female

Address | City | State | Zip Code

E-mail | Date of Birth | Marital Status

Cell Phone # | Home Phone # | Work Phone #

Referred by | How did you hear about us?

Employment Information

Employer

Occupation

Job Duties

Emergency Contact

Name | Relationship | Contact Number

☐ Do we have permission to discus your medical condition with this person, if there is an EMERGENCY ? (click for yes)

Insurance Information

Insurance Carrier | Policy Number

Primary Care Physician | Contact Number

ASSIGNEMENT OF INSURANCE INFORMATION AND BENEFITS

I herby authorize the insurance carrier listed above to make payments directly to the Health Care Provider and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, It is my responsibility to notify the Health Care Provider; otherwise I will be responsible for payment

Last Name | First Name | Date

Signature

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Chief Complaint Form

Patient Information

Last Name | MI | First Name | Date of Birth

Chief Complaint

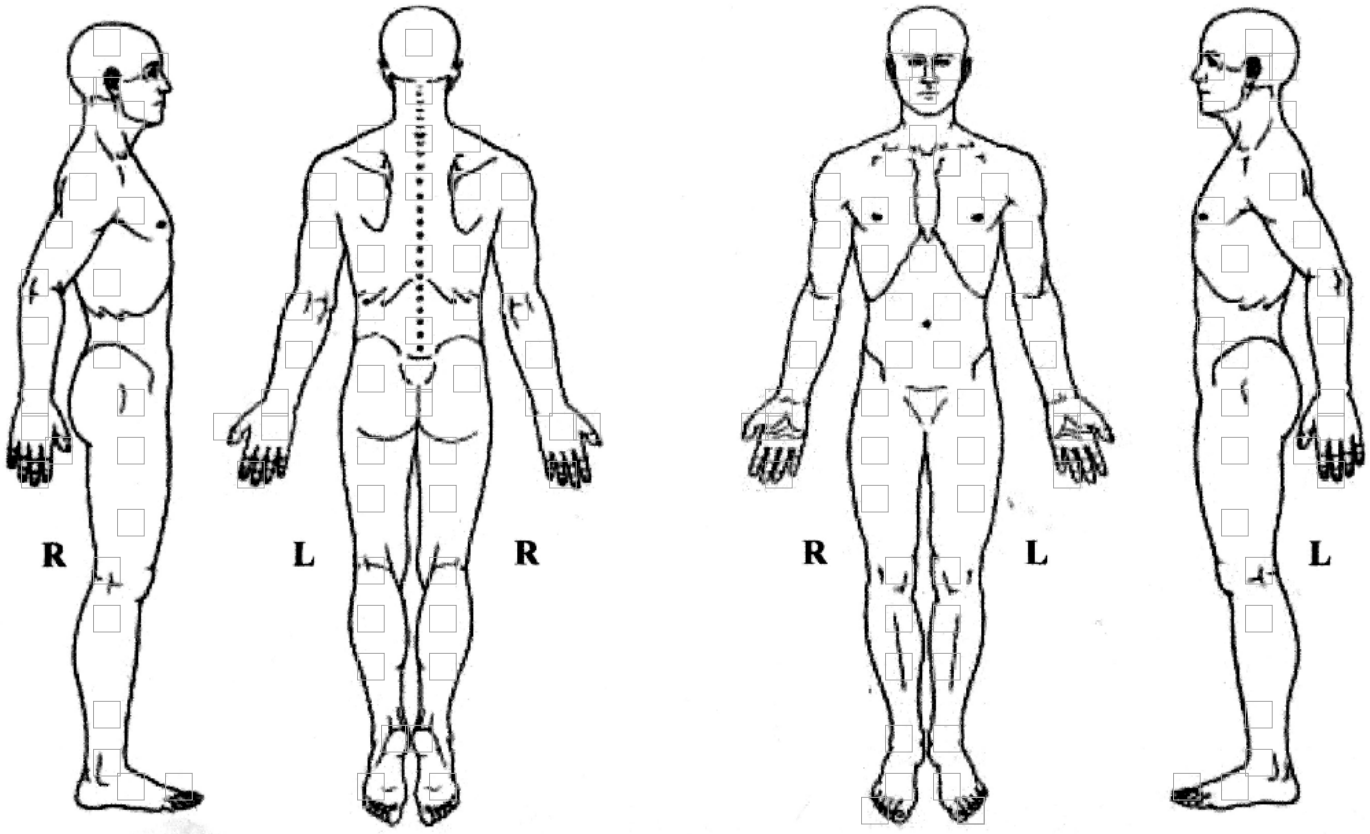
CURRENT CONDITION, WHAT BRINGS YOU TO OUR OFFICE TODAY? List in order of severity.

Condition #1

Condition #2

Condition #3

PLEASE CLICK WHERE YOU ARE EXPERIENCING PAIN:



When did the condition start and what was the cause?

Condition #1

Condition #2

Condition #3

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Chief Complaint Form

List any treatments that you have done for the condition and what was the result of the treatment.

Condition #1

Condition #2

Condition #3

What makes the condition better? What makes it worse?

Condition #1

Condition #2

Condition #3

Describe you pain sensation?

Condition #1 Condition #2 Condition #3

Is the condition constant or does it come and go?

Condition #1 Condition #2 Condition #3

Does your pain travel? If so, where does it travel to?

Condition #1

Condition #2

Condition #3

What is your pain level today 0-10? (0 = No pain 10 = Extreme pain)

Condition #1 Condition #2 Condition #3

What is your pain level when it started 0-10? (0 = No pain 10 = Extreme pain)

Condition #1 Condition #2 Condition #3

Is your condition worse at different times of the day, months or season? Please explain.

Condition #1

Condition #2

Condition #3

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Review Of Systems

Patient Information

Last Name | First Name | MI | Date of Birth

Medical Information

Please check the following conditions: ◯ Previously had ☐ Currently have

General

◯ ☐ Recent weight gain	◯ ☐ Loss of sleep	◯ ☐ Fatigue	◯ ☐ Rheumatic fever
◯ ☐ Recent weight loss	◯ ☐ Loss of appetite	◯ ☐ Polio	◯ ☐ Cancer of any kind

Integumentary system (skin)

◯ ☐ Skin problems	◯ ☐ Skin rash	◯ ☐ Psoriasis	◯ ☐ Skin cancer
◯ ☐ Slow healing	◯ ☐ Skin discoloration	◯ ☐ Change in mole	◯ ☐ Scars
◯ ☐ Bruise easily	◯ ☐ Itching	◯ ☐ Change in skin color	◯ ☐ Sores

Neurological

◯ ☐ Light headed/dizziness	◯ ☐ Fainting	◯ ☐ Disorientation	◯ ☐ Weakness
◯ ☐ Memory loss	◯ ☐ Concussion	◯ ☐ Loss of coordination	◯ ☐ Numbness
◯ ☐ Difficult speaking	◯ ☐ Migraines	◯ ☐ Difficulty walking	◯ ☐ Tingling
◯ ☐ Multiple sclerosis	◯ ☐ Headaches	◯ ☐ Stroke	◯ ☐ Tremors
◯ ☐ Parkinson's disease	◯ ☐ Epilepsy/Seizures	◯ ☐ Alzheimer's Disease	◯ ☐ Disk problems

Eyes, Ears, Nose and Throat

◯ ☐ Vison problems	◯ ☐ Glaucoma	◯ ☐ Ear Pain	◯ ☐ Sore throat
◯ ☐ Blurred vision	◯ ☐ Hearing loss	◯ ☐ Mouth sores	◯ ☐ Dental problems
◯ ☐ Double vision	◯ ☐ Ear noises	◯ ☐ Hoarse voice	◯ ☐ Nose bleeds

Endocrine system

◯ ☐ Hypothyroid	◯ ☐ Hyperthyroid	◯ ☐ Daibetes	◯ ☐ Goiter

Respiratory

◯ ☐ Coughing	◯ ☐ Pneumonia	◯ ☐ Superficial breathing	◯ ☐ Bronchitis
◯ ☐ Coughing blood	◯ ☐ Difficulty breathing	◯ ☐ Chest pain	◯ ☐ Emphysema
◯ ☐ Chronic cough	◯ ☐ Asthma	◯ ☐ Tuberculosis	◯ ☐ Lung cancer

Cardiovascular

◯ ☐ Pain over heart	◯ ☐ Pressure over chest	◯ ☐ High blood pressure	◯ ☐ Shortness of breath
◯ ☐ Heart attack	◯ ☐ Pain down left arm	◯ ☐ Low blood pressure	◯ ☐ Profuse sweating
◯ ☐ Irregular heartbeat	◯ ☐ Cardiomegaly	◯ ☐ High triglycerides	◯ ☐ Nausea
◯ ☐ Heart murmurs	◯ ☐ Swelling of ankles	◯ ☐ High Cholesterol	◯ ☐ Vomitting

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Review Of Systems

Please check the following conditions: ◯ Previously had ☐ Currently have

Gastrointestinal

◯ ☐ Gallbladder problems	◯ ☐ Pain over stomach	◯ ☐ Constipation	◯ ☐ Blood in stool
◯ ☐ Liver trouble	◯ ☐ Burning in stomach	◯ ☐ Diarrhea	◯ ☐ Mucus in stool
◯ ☐ Hepatitis	◯ ☐ Ulcers	◯ ☐ Hiatal Hernia	◯ ☐ Pancreatitis
◯ ☐ Distress from greasy food	◯ ☐ Heartburn	◯ ☐ Colitis	◯ ☐ Colon cancer

Genitourinary

◯ ☐ Painful urination	◯ ☐ Frequent urination	◯ ☐ Kidney infection	◯ ☐ Kidney stones
◯ ☐ Blood in urine	◯ ☐ Incontinence	◯ ☐ Sexual difficulty	◯ ☐ Loss of libido
◯ ☐ Burning urination	◯ ☐ Difficulty starting urination	◯ ☐ Dribbling after urination	◯ ☐ Nightly urination

Hematologic (blood)

◯ ☐ Anemia	◯ ☐ Bleeding disorder	◯ ☐ Sickle cell anemia	◯ ☐ Lymphoma

Musculoskeletal

◯ ☐ Arthritis	◯ ☐ Head injury	◯ ☐ Cancer	◯ ☐ Muscle pain
◯ ☐ Osteoarthritis	◯ ☐ Neck injury	◯ ☐ Muscle weakness	◯ ☐ Gout
◯ ☐ Rheumatoid arthritis	◯ ☐ Back injury	◯ ☐ Osteoporosis	◯ ☐ Scoliosis
◯ ☐ Bone spurs	◯ ☐ Spinal trauma	◯ ☐ Muscular Dystrophy	◯ ☐ Lupus
◯ ☐ Broken bones	◯ ☐ Birth trauma	◯ ☐ Scheuerman's disease	◯ ☐ Spina bifida
◯ ☐ Compression fracture	◯ ☐ Birth defects	◯ ☐ Joint pain	◯ ☐ Spondylolisthesis

Allergic/Immunology

◯ ☐ Catch colds easily	◯ ☐ HIV	◯ ☐ Frequent influenza	◯ ☐ Fever
◯ ☐ Frequent sinus trouble	◯ ☐ AIDS	◯ ☐ Allergies	◯ ☐ Hay Fever

Women only

◯ ☐ Irregular menses	◯ ☐ Premenstrual depression	◯ ☐ Abnormal pap smear	◯ ☐ Uterine cyst
◯ ☐ Vaginal discharge	◯ ☐ Menstrual cramps	◯ ☐ Lumps in breast	◯ ☐ Uterine fibroids
◯ ☐ Hot flashes	◯ ☐ Nipple discharge	◯ ☐ Hysterectomy	◯ ☐ Uterine cancer

Men only

◯ ☐ Prostate trouble
◯ ☐ Prostate cancer

Last Name _____ First Name _____ Date _____

Signature _____

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Family & Past Medical History

Patient Information

Last Name | First Name | MI | Date of Birth

Family History

Please select if anyone in your family have had any of the following conditions.

Stroke		Cancer		Bleeding Disorder	
Osteoperosis		Type of Cancer		High Blood Pressure	
Diabetes		Heart Attack		Genetic Disorder	

Any other disease that multiple family members have. Please list.

Please list disease related to death.

Mother's age	Cause of death	Grandmother's age	Cause of death
Father's age	Cause of death	Grandfather's age	Cause of death

Allergies

List all known allergies

Accidents

Please list any past accidents, severe falls, major injuries, as well as fractures and dislocations.

Year		Type of accident		Residual problem	
Year		Type of accident		Residual problem	
Year		Type of accident		Residual problem	
Year		Type of accident		Residual problem	
Year		Type of accident		Residual problem	

Surgeries and Hospitalization

Please list any surgeries or hospitalizations.

Year		Type		Residual problem	
Year		Type		Residual problem	
Year		Type		Residual problem	
Year		Type		Residual problem	
Year		Type		Residual problem	

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Family & Past Medical History

Medications and Supplements

Please list **ALL** medication that you are taking.

Medication		Milligrams/day		Medication		Milligrams/day	
Medication		Milligrams/day		Medication		Milligrams/day	
Medication		Milligrams/day		Medication		Milligrams/day	
Medication		Milligrams/day		Medication		Milligrams/day	

Please list **ALL** supplements (S), herbs (H), vitamins (V) and over the counter drug (OTC) that you are taking.

S, H, V, OTC		Milligrams/day		S,H,V,OTC		Milligrams/day	
S, H, V, OTC		Milligrams/day		S,H,V,OTC		Milligrams/day	
S, H, V, OTC		Milligrams/day		S,H,V,OTC		Milligrams/day	
S, H, V, OTC		Milligrams/day		S,H,V,OTC		Milligrams/day	

Other

Please list any other diseases or conditions not mentioned.

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Patient Privacy Form

Patient Information

Last Name | MI | First Name | Date of Birth

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Forever Young Holistic Center LLC is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT
We may disclosure your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

WORKERS COMPENSATION
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICAL AND ADMINISTRATIVE PROCEEDINGS
We may disclose your health information in the course of any administrative or judicial proceedings.

LAW ENFORCEMENT
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS
We may disclose your information to coroners or medical examiners.

ORGAN DONATION
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES
We may disclose your health information for military, national security, prisoner and government benefits purposes.

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MARKETING
We may contact your for marketing purposes or fund raising purposes.

CHANGE OF OWNERSHIP
In the event that Forever Young Holistic Center LLC is sold or merged with another organization your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS
You have the right to request restriction on certain uses and disclosures of your health information. Please be advised, however, that Forever Young Holistic Center LLC is not required to agree to the restriction that you request.

You have the right to have your health information received and communicated through an alternative method or sent to an alternative location other that the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have the right to request that Forever Young Holistic Center LLC amend your protected health information. Please be advised, however, that Forever Young Holistic Center LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, your will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting disclosures of your protected health information by Medicinal Life LLC.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES
Forever Young Holistic Center LLC reserves the right to amend this notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Forever Young Holistic Center LLC is required by law to comply with this notice.

Forever Young Holistic Center LLC is required by law to maintain the privacy of your health information and to provide you of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy right, please contact: Forever Young Holistic Center LLC by calling this office at 407-412-6354. If Forever Young Holistic Center LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS
Complaints about your privacy rights, or how Forever Young Holistic Center LLC has handled your health information should be directed to Forever Young Holistic Center LLC by calling this office at 407-412-6354. If Forever Young Holistic Center LLC is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of today's date listed below.
I have read the privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Forever Young Holistic Center LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Last Name _____ First Name _____ Date _____

Signature _____