BALLEN MEDICAL & WELLNESS

COLORADO RECOVERY INFUSION CENTER

Functional Medicine New Patient Intake Form

Name: _____ Appointment Date: _____

Age: _____ Gender: ☐M ☐F Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email Address: _____ Can we contact you by email? ☐Y ☐N

Occupation: _____ Employer: _____

Work Phone: _____

Current Height: _____ Current Weight: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone #: _____

Check this box to join our email list. You'll receive occasional IV therapy announcements and featured offers, as well as our monthly integrative health newsletter created in partnership with *Ballen Medical & Wellness*. Your email will never be shared with any third parties.

How did you hear about us?

☐5280 Magazine ☐Instagram
☐Facebook ☐ZocDocs
☐Google ☐Other (please specify): _____

Appointment Reminders: Ballen Medical & Wellness' scheduling platform, Power2Practice, initiates appointment reminder notices via email and text 3 days prior to your scheduled appointment.

Insurance Information:**Ballen Medical & Wellness and Colorado Recovery Infusion Center are not contracted with any medical insurances, however there are instances where we may require your insurance information (i.e. Lab Orders, Prescription Prior Authorizations, Insurance calls for submitted superbills).**

Insurance Carrier: _____ Insurance Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber ID #: _____ Group #: _____

Relation to Subscriber: _____

Pharmacy Information:

Patient's Legal Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Medical History

Allergies:

Are you allergic to any medications? _____

Are you allergic to any supplements? _____

Are you allergic to any foods? _____

Medications:

Please list **ALL** current prescription(s) and Over the Counter medications:

_____ _____

_____ _____

_____ _____

_____ _____

Previous (last 10 years): Please specify medication dose, frequency, start date, and reason for use.

_____

_____

_____

_____

_____

_____

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy):

Please specify supplement, dose, frequency, start date, and reason for use

_____

_____

_____

_____

_____

_____

Have your medications or supplements ever caused you unusual side effects or problems? ☐Yes ☐No

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐Yes ☐No

Have you had prolonged or regular use of Tylenol? ☐Yes ☐No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)? ☐Yes ☐No

Frequent antibiotics (more than 3 times/year)? ☐Yes ☐No

Long term antibiotics? ☐Yes ☐No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ☐Yes ☐No

Use of oral contraceptives? ☐Yes ☐No

Use of statins? ☐Yes ☐No

What do you hope to achieve with us? _____

_____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair	Poor
Ex: Postnasal drip	✓			**Ex: Elimination diet**	✓			

Disease/Diagnosis/Conditions

Check appropriate box **P = Past Condition C = Current Condition** and provide date of onset (mm/yyyy)

P	C	Gastrointestinal	Date
☐	☐	Irritable Bowel Syndrome	
☐	☐	Inflammatory Bowel Disease	
☐	☐	Crohn's	
☐	☐	Ulcerative Colitis	
☐	☐	Gastric or Peptic Ulcer Disease	
☐	☐	GERD (reflux)	
☐	☐	Celiac Disease	
☐	☐	Other:	

P	C	Cardiovascular	Date
☐	☐	Heart attack	
☐	☐	Other heart disease	
☐	☐	Stroke	
☐	☐	Elevated cholesterol	
☐	☐	Arrhythmia (irregular heart rate)	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Rheumatic fever	
☐	☐	Mitral valve prolapse	
☐	☐	Other:	

P	C	Metabolic/Endocrine	Date
☐	☐	Type 1 Diabetes	
☐	☐	Type 2 Diabetes	
☐	☐	Hypoglycemia	
☐	☐	Metabolic Syndrome (insulin resistance or pre-diabetes)	
☐	☐	Hypothyroidism (low thyroid)	
☐	☐	Hyperthyroidism (overactive thyroid)	
☐	☐	Endocrine problems	
☐	☐	Polycystic Ovarian Syndrome (PCOS)	
☐	☐	Infertility	
☐	☐	Weight gain	
☐	☐	Weight loss	
☐	☐	Frequent weight fluctuations	
☐	☐	Bulimia	
☐	☐	Anorexia	
☐	☐	Binge eating disorder	
☐	☐	Night eating syndrome	
☐	☐	Eating disorder (non-specific)	
☐	☐	Other:	

P	C	Genital & Urinary Systems	Date
☐	☐	Kidney stones	
☐	☐	Gout	
☐	☐	Interstitial cystitis	
☐	☐	Frequent urinary tract infections	
☐	☐	Frequent yeast infections	
☐	☐	Erectile or sexual dysfunction	
☐	☐	Other:	

P	C	Inflammatory/Autoimmune	Date
☐	☐	Chronic Fatigue Syndrome	
☐	☐	Autoimmune Disease	
☐	☐	Rheumatoid Arthritis	
☐	☐	Lupus SLE	
☐	☐	Immune deficiency disease	
☐	☐	Herpes-genital	
☐	☐	Severe infectious disease	
☐	☐	Poor Immune Function (frequent infections)	
☐	☐	Food allergies	
☐	☐	Environmental Allergies	
☐	☐	Multiple chemical sensitivities	
☐	☐	Latex allergy	
☐	☐	Other:	

P	C	Respiratory Diseases	Date
☐	☐	Asthma	
☐	☐	Chronic sinusitis	
☐	☐	Emphysema	
☐	☐	Pneumonia	
☐	☐	Tuberculosis	
☐	☐	Sleep apnea	
☐	☐	Other:	

P	C	Skin Diseases	Date
☐	☐	Eczema	
☐	☐	Psoriasis	
☐	☐	Acne	
☐	☐	Melanoma	
☐	☐	Skin cancer	
☐	☐	Other:	

Check appropriate box **P = Past Condition C = Current Condition** and provide date of onset (mm/yyyy)

P	C	Cancer	Date
☐	☐	Lung cancer	
☐	☐	Breast cancer	
☐	☐	Colon cancer	
☐	☐	Ovarian cancer	
☐	☐	Prostate cancer	
☐	☐	Other:	

P	C	Musculoskeletal/Pain	Date
☐	☐	Osteoarthritis	
☐	☐	Fibromyalgia	
☐	☐	Chronic pain	
☐	☐	Other:	

P	C	Neurologic/Mood	Date
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Bipolar Disorder	
☐	☐	Schizophrenia	
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	ADD/ADHD	
☐	☐	Autism	

P	C	Neurologic/Mood Continued	Date
☐	☐	Mild cognitive impairment	
☐	☐	Memory problems	
☐	☐	Parkinson's Disease	
☐	☐	Multiple Sclerosis	
☐	☐	ALS	
☐	☐	Seizures	
☐	☐	Other:	

Preventative Test & Date of Last Test	Date
Full physical exam	
Bone density	
Colonoscopy	
Cardiac stress test	
EBT heart scan	
EKG	
Hemoccult Test – stool test for blood	
MRI	
CT Scan	
Upper Endoscopy	
Upper GI Series	
Ultrasound	
Digital rectal exam	

Surgeries	Date
☐ None	
Appendectomy	
Hysterectomy +/- Ovaries	
Gall Bladder	
Hernia	
Tonsillectomy	
Dental surgery	
Joint replacement – knee/hip	
Heart surgery – bypass valve	
Angioplasty or stent	
Pacemaker	
Other:	

Injuries:

☐ Back injury ☐ Head injury ☐ Neck injury ☐ Broken bones

☐ Other: _____

Blood Type:

☐ A ☐ O ☐ AB ☐ Rh+ ☐ Unknown

Hospitalizations:

☐ None

Date & reason: _____

Medical History Comments: _____

_____

_____

Gynecologic History

Obstetric History:

Are you currently pregnant? ☐ Yes ☐ No ☐ Maybe

Have you been pregnant in the past? If yes, provide number of:

Pregnancies	_____	Gestational Diabetes	_____
Miscarriage	_____	Baby over 8 pounds	_____
Abortion	_____	Breastfeeding (# mo.)	_____
Vaginal deliveries	_____	Postpartum Depression	_____
Caesarean	_____	Living children	_____
Toxemia	_____		

Menstrual History:

Age at first period _____ Menses frequency _____ Length _____

Pain ☐ Yes ☐ No

Clotting ☐ Yes ☐ No

Has your period ever skipped? ☐ Yes ☐ No

Last menstrual period _____

Do you use contraception? ☐ Yes ☐ No

Women's Disorders/Hormonal Imbalances: Check all that apply

☐ Fibrocystic breasts	☐ Endometriosis	☐ Fibroids
☐ Painful periods	☐ Heavy periods/bleeding	☐ Infertility
☐ Hot flashes	☐ Mood swings	☐ PMS
☐ Vaginal dryness	☐ Decreased libido	☐ Concentration/memory problems
☐ Joint pains	☐ Headaches	☐ Weight gain
☐ Loss of control of urine	☐ Palpitations	☐ In menopause?
☐ Breast biopsy	☐ Hormone Replacement Therapy	Age at menopause _____

Last PAP Test: ☐ Normal ☐ Abnormal

Last Mammogram: ☐ Normal ☐ Abnormal

Date of Last Bone Density: _____ Results: ☐ High ☐ Low ☐ Normal

GI (Gastrointestinal) History:

Foreign travel? ☐ Yes ☐ No

Wilderness camping? ☐ Yes ☐ No

Have you ever had severe ☐ Gastroenteritis ☐ Diarrhea?

Have you ever been diagnosed with IBS (Irritable Bowel Syndrome)? ☐ Yes ☐ No

Patient (Your) Birth History:

☐ Term ☐ Premature ☐ Vaginal birth ☐ C-Section

Pregnancy Complications: _____

_____

_____

Birth complications: _____

_____

_____

☐ Breast fed ☐ Bottle fed

Age at introduction of Solid foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

Dental History:

☐ Silver mercury fillings	☐ Tooth pain
☐ Gold fillings	☐ Bleeding gums
☐ Root canals	☐ Gingivitis
☐ Implants	☐ Problems w/chewing

Do you floss regularly? ☐ Yes ☐ No

Social History

Nutrition History:

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

How often to you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No

Do you avoid any particular food? ☐ Yes ☐ No

If you could only eat a few foods a week, what would they be? _____

_____

How many times do you eat fish per week? _____

Do you grocery shop? ☐Yes ☐No

Do you read food labels? ☐Yes ☐No

Do you cook? ☐Yes ☐No

How many times do you eat out per week? _____

Check all the factors that apply to your current lifestyle and eating habits:

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

The most important thing I should change about my diet to improve my health is: _____

_____

_____

List the three worst foods you eat during the average week:

1. _____
2. _____
3. _____

List the three healthiest foods you eat during the average week:

1. _____
2. _____
3. _____

Smoking:

Currently smoking? ☐Yes ☐No

Previous smoking? ☐Yes ☐No

Secondhand smoke exposure? ☐Yes ☐No

Alcohol Intake:

How many drinks currently per week? (1 drink = 5 oz. wine, 12 oz. beer, 1.5 oz. spirits)

☐None ☐1-3 ☐4-6 ☐7-10 ☐>10

Previous alcohol intake? ☐None ☐1-3 ☐4-6 ☐7-10 ☐>10

Have you ever been told you should cut down your alcohol intake? ☐Yes ☐No

Do you get annoyed when people ask you about your drinking? ☐Yes ☐No

Do you ever feel guilty about your alcohol consumption? ☐Yes ☐No

Do you ever take a drink to get going when you wake? ☐Yes ☐No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐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

Have you ever thought about getting help to control or stop your drinking? ☐Yes ☐No

Other Substances:

Caffeine intake ☐Yes ☐No

Are you currently using recreational drugs? ☐Yes ☐No

Have you ever used IV or inhaled recreational drugs? ☐Yes ☐No

Exercise:

Stretching (type) _____ _____/week _____ minutes

Cardio/Aerobics (type): _____ _____/week _____ minutes

Strength Training (type): _____ _____/week _____ minutes

Other Exercise (type): _____ _____/week _____ minutes

Sports or Leisure Activities (type): _____ _____/week _____ minutes

Rate your level of motivation for including exercise in your life: ☐Low ☐Medium ☐High

List problems that limit activity: _____

_____

_____

Do you feel unusually fatigued after exercise? ☐Yes ☐No

Do you usually sweat when exercising? ☐Yes ☐No

Psychosocial:

Do you feel significantly less vital than you did a year ago? ☐Yes ☐No

Are you happy? ☐Yes ☐No

Do you feel your life has meaning and purpose? ☐Yes ☐No

Do you believe stress is presently reducing the quality of your life? ☐Yes ☐No

Do you like the work you do? ☐Yes ☐No

Have you experienced major losses in your life? ☐Yes ☐No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐Yes ☐No

Would you describe your experience as a child in your family as happy and secure? ☐Yes ☐No

How often do you laugh? _____

What do you do to nurture yourself? _____

How do you express yourself creatively? _____

What give you joy/passion? _____

Do you have spiritual practice? _____

Is sexual abuse/molestation and/or physical violence an issue to discuss? ☐Yes ☐No

Stress/Coping:

Have you ever sought counseling? ☐Yes ☐No

Are you currently in therapy? ☐Yes ☐No

Do you feel you have an excessive amount of stress in your life? ☐Yes ☐No

Do you feel you can easily handle the stress in your life? ☐Yes ☐No

Daily stressors – rate on scale of 1-10:

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? ☐Yes ☐No

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐Yes ☐No

Sleep/Rest:

Average number of hours you sleep per night: ☐> 10 ☐8-10 ☐6-8 ☐<6

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 have problems with insomnia? ☐Yes ☐No

Do you snore? ☐Yes ☐No

Do you use sleeping aids? ☐Yes ☐No

Roles/Relationships:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widowed

Gender (biological sex) of sexual partner(s): ☐ Male ☐ Female

Are you satisfied with your sex life? ☐ Yes ☐ No

List Children (name, age, gender, living at home):

_____

_____

_____

_____

List others living in household (person's name, occupation, and relation):

_____

_____

_____

Total number living in household: _____

Resources for emotional support (check all that apply):

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

How well have things been going for you?	**Very Well**	**Fine**	**Poorly**	**N/A**
Overall	☐	☐	☐	☐
At school	☐	☐	☐	☐
In your job	☐	☐	☐	☐
In your social life	☐	☐	☐	☐
With close friends	☐	☐	☐	☐
With sex	☐	☐	☐	☐
With your attitude	☐	☐	☐	☐
With your relationship	☐	☐	☐	☐
With your children	☐	☐	☐	☐
With your parents	☐	☐	☐	☐

Environmental and Detoxification Assessment:

Do you have any food allergies? Sensitivities, or adverse food reactions? ☐ Yes ☐ No

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

Do you adversely react to…? Check all that apply:

☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus foods ☐ Chocolate ☐ Alcohol

☐ Red Wine ☐ Sulfite-containing Foods (wine, dried fruit, salad bars) ☐ Monosodium Glutamate (MSG)

☐ Aspartame (NutraSweet) ☐ Preservatives (ex: sodium benzoate) ☐ Other: _____

Which of these do you have intolerances to? Check all that apply:

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Exhaust fumes ☐ Jewelry

☐ Shampoo, lotion, detergents, etc. ☐ Multiple smell & chemical sensitivities ☐ Constant skin outbreaks

☐ Other: _____

In you work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's Syndrome or a liver disorder? ☐ Yes ☐ No

Do you have a known history of significant exposure to any harmful chemicals such as the following?

☐ Herbicides ☐ Pesticides ☐ Insecticides (frequent visits of exterminator) ☐ Heavy metals

☐ Organic solvents ☐ Other: _____

Chemical name(s), date(s), & length of exposure:

_____

_____

_____

_____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had another mold exposure? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

Family History

Check family members that apply.
Enter ages and conditions for multiple family members of the same relation in the same column.

M = Mother F = Father B = Brother S = Sister C = Child
Ma = Maternal Pa = Paternal Gma = Grandmother Gpa = Grandfather
A = Aunt U = Uncle

	M	F	B	S	C	Ma Gma	Ma Gpa	Pa Gma	Pa Gpa	A	U
Age (if still alive)											
Age at death (if deceased)											
Cancers											
Colon Cancer											
Breast or Ovarian Cancer											
Heart Disease											
Hypertension											
Obesity											
Stroke											
Inflammatory Arthritis Rheumatoid, Psoriatic, Ankylosing Spondylitis											
Multiple Sclerosis											
Auto Immune Diseases (Lupus)											
Irritable Bowel Syndrome											
Inflammatory Bowel Disease											
Celiac Disease											
Asthma											
Eczema/Psoriasis											
Food Allergies or Intolerances											
Environmental Sensitivities											
Dementia											
Parkinson's											
Motor Neuron Diseases (ALS)											
Genetic Disorders											
Substance Abuse (Alcohol or Drugs)											
Psychiatric Disorders											
Depression											
Schizophrenia											
ADHD											
Autism											
Bipolar											

Symptom Questionnaire:

Please check all current symptoms occurring or present in the past 6 months.

General

- ☐ Cold hands & feet
- ☐ Cold intolerance
- ☐ Low body temperature
- ☐ Low blood pressure
- ☐ Daytime sleepiness
- ☐ Difficulty falling asleep
- ☐ Early waking
- ☐ Fatigue
- ☐ Insomnia
- ☐ Fever
- ☐ Flushing
- ☐ Heat intolerance
- ☐ Night waking
- ☐ Nightmares
- ☐ No dream recall
- ☐ Night sweats
- ☐ Sweating for no reason

Head, Eyes, & Ears

- ☐ Conjunctivitis
- ☐ Distorted sense of smell
- ☐ Distorted taste
- ☐ Ear fullness
- ☐ Ear pain
- ☐ Ear ringing or buzzing
- ☐ Lid margin redness
- ☐ Eye crusting
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Hearing problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to loud noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous detachment
- ☐ Retinal detachment
- ☐ Morning headaches
- ☐ Thinning eyebrows

Eating

- ☐ Binge eating
- ☐ Bulimia
- ☐ Can't gain weight
- ☐ Can't lose weight
- ☐ Can't maintain healthy weight
- ☐ Frequent dieting
- ☐ Poor appetite
- ☐ Salt cravings
- ☐ Carbohydrate cravings (breads)
- ☐ Sweet cravings (candy, cookies)
- ☐ Chocolate cravings
- ☐ Caffeine dependency
- ☐ Irritable if meals are missed

Respiratory

- ☐ Bad breath
- ☐ Bad odor in nose
- ☐ Cough - dry
- ☐ Cough - productive
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Hay Fever – Spring
- ☐ Hay Fever – Summer
- ☐ Hay Fever – Fall
- ☐ Hay Fever – Change of season
- ☐ Nasal stuffiness
- ☐ Nose bleeds
- ☐ Postnasal drip
- ☐ Sinus fullness
- ☐ Sinus infection
- ☐ Snoring
- ☐ Wheezing

Cardiovascular

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart murmur
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen ankles/feet
- ☐ Varicose veins

Itching Skin

- ☐ Skin in general
- ☐ Anus
- ☐ Arms
- ☐ Ear canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of mouth
- ☐ Scalp

Skin, Dryness of:

- ☐ Eyes
- ☐ Feet, w/cracking
- ☐ Feet, w/peeling
- ☐ Hair
- ☐ Hands, w/cracking
- ☐ Hands, w/peeling
- ☐ Mouth/throat
- ☐ Scalp
- ☐ Dandruff
- ☐ Skin in general

Urinary

- ☐ Bed wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney disease
- ☐ Leaking/incontinence
- ☐ Pain/burning
- ☐ Prostate infection
- ☐ Urgency
- ☐ Frequent urinations

Skin Problems

- [ ] Acne on back
- [ ] Acne on chest
- [ ] Acne on face
- [ ] Acne on shoulders
- [ ] Athlete's foot
- [ ] Bumps on back of upper arms
- [ ] Cellulite
- [ ] Dark circles under eyes
- [ ] Ears get red
- [ ] Easy bruising
- [ ] Lack of sweating
- [ ] Eczema
- [ ] Hives
- [ ] Jock itch
- [ ] Lackluster skin
- [ ] Moles w/color/size change
- [ ] Oily skin
- [ ] Pale skin
- [ ] Patchy dullness
- [ ] Rash
- [ ] Red face
- [ ] Sensitivity to bites
- [ ] Sensitivity to poison ivy/oak
- [ ] Shingles
- [ ] Skin darkening
- [ ] Strong body odor
- [ ] Hair loss
- [ ] Vitiligo
- [ ] Excess hair growth

Nails

- [ ] Bitten
- [ ] Brittle
- [ ] Curved up
- [ ] Frayed
- [ ] Fungus – fingernails
- [ ] Fungus – toenails
- [ ] Pitting
- [ ] Ragged cuticles
- [ ] Ridges
- [ ] Soft nails
- [ ] Thickening of fingernails
- [ ] Thickening of toenails
- [ ] White spots/lines

Mood/Nerves

- [ ] Agoraphobia
- [ ] Anxiety
- [ ] Auditory hallucinations
- [ ] Black-out
- [ ] Depression
- [ ] Difficulty concentrating
- [ ] Difficulty w/balance
- [ ] Difficulty w/thinking
- [ ] Difficulty w/judgment
- [ ] Difficulty w/speech
- [ ] Difficulty w/memory
- [ ] Dizziness (spinning)
- [ ] Fainting
- [ ] Fearfulness
- [ ] Irritability
- [ ] Light-headedness
- [ ] Numbness
- [ ] Other phobias
- [ ] Panic attacks
- [ ] Paranoia
- [ ] Seizures
- [ ] Suicidal thoughts
- [ ] Tingling
- [ ] Tremor/Trembling
- [ ] Visual hallucinations
- [ ] Nervousness

Lymph Nodes

- [ ] Enlarged/neck
- [ ] Tender/neck
- [ ] Other enlarged/tender

Female Reproductive

- [ ] Breast cysts
- [ ] Breast tenderness
- [ ] Breast lumps
- [ ] Ovarian cyst(s)
- [ ] Poor libido (sex drive)
- [ ] Vaginal discharge
- [ ] Vaginal odor
- [ ] Vaginal itch
- [ ] Vaginal pain w/sex

Musculoskeletal

- [ ] Back muscle spasm
- [ ] Calf cramps
- [ ] Chest tightness
- [ ] Food cramps
- [ ] Joint deformity
- [ ] Joint pain
- [ ] Joint redness
- [ ] Joint stiffness
- [ ] Muscle pain
- [ ] Muscle spasms
- [ ] Muscle stiffness
- [ ] Muscle twitches around eye
- [ ] Muscle twitches arms or legs
- [ ] Muscle weakness
- [ ] Neck muscle spasm
- [ ] Tendonitis
- [ ] Tension headache
- [ ] TMJ problems

Premenstrual

- [ ] Bloating or breast tenderness
- [ ] carbohydrate cravings
- [ ] Chocolate cravings
- [ ] Constipation
- [ ] Decreased sleep
- [ ] Diarrhea
- [ ] Fatigue
- [ ] Increased sleep
- [ ] Irritability or depression
- [ ] Acne
- [ ] Facial hair growth

Menstrual

- [ ] Cramps
- [ ] Heavy periods
- [ ] Irregular periods
- [ ] No periods
- [ ] Scanty periods
- [ ] Spotting between
- [ ] Breast pain
- [ ] Pelvic pain

Digestion

- [ ] Bad teeth
- [ ] Bleeding gums
- [ ] Canker sores
- [ ] Cold sores
- [ ] Cracking at corner of lips
- [ ] Dentures w/poor chewing
- [ ] Difficulty swallowing
- [ ] Dry mouth
- [ ] Coated tongue/fuzzy debris
- [ ] Foods "Repeat" (Reflux)
- [ ] Burping
- [ ] Heartburn
- [ ] Indigestions
- [ ] Use antacids
- [ ] Intolerance to lactose
- [ ] Intolerance to gluten (wheat, rye)
- [ ] Intolerance to greasy/high fat foods
- [ ] Intolerance to corn
- [ ] Intolerance to eggs
- [ ] Intolerance to fatty foods
- [ ] Intolerance to yeast
- [ ] Pain after eating
- [ ] Bloating of lower abdomen
- [ ] Bloating of whole abdomen
- [ ] Bloating after meals
- [ ] Nausea
- [ ] Vomiting
- [ ] Upper abdominal pain
- [ ] Lower abdominal pain
- [ ] Hungry 1-2 hours after meal
- [ ] Indigestion & fullness last 2-4 hours after eating
- [ ] Sense of fullness after meals
- [ ] Feel like you digest your food well
- [ ] Liver disease/Jaundice
- [ ] Abnormal liver function tests
- [ ] Anal spasms
- [ ] Excess flatulence/Gas
- [ ] Gas
- [ ] Cramps
- [ ] Constipation
- [ ] Diarrhea
- [ ] Alternating diarrhea & constipation
- [ ] More than 3 bowel movements per day
- [ ] Feeling bowels do not empty completely
- [ ] Hemorrhoids
- [ ] Fissures
- [ ] Blood in stools
- [ ] Clay colored stools
- [ ] Greasy stools
- [ ] Use laxatives
- [ ] Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

Menopausal Females Only

How many years have you been menopausal? _____ years

Since menopause, do you ever have: Check all that apply

- ☐ Uterine bleeding
- ☐ Hot flashes
- ☐ Mental fogginess
- ☐ Disinterest in sex
- ☐ Mood swings
- ☐ Depression
- ☐ Painful intercourse
- ☐ Shrinking breasts
- ☐ Facial hair growth
- ☐ Acne
- ☐ Increased vaginal pain, dryness, or itching

Male Reproductive: Check all that apply

- ☐ Decreased libido
- ☐ Decrease number of morning erections
- ☐ Decrease fullness of erections
- ☐ Spells of mental fatigue
- ☐ Inability to concentrate
- ☐ Episodes of depression
- ☐ Muscle soreness
- ☐ Decrease physical stamina
- ☐ Unexplained weight gain
- ☐ Increased fat distribution around chest/hips
- ☐ Increased abdominal fat
- ☐ Sweaty attacks
- ☐ More emotional than past

****If you have significant medical history (i.e. cardiac, Lyme, mold, autoimmune, infections, thyroid, or diabetes), it would be beneficial to submit a Release of Information (see page 19) to us so we can obtain your medical records prior to your initial appointment. If you have access to current medical records (i.e. labs or any medical records), please send those to us prior to your initial appointment. Bring copies to your appointment as well.**

****Please bring all current medication(s) and/or supplements to your appointment.**

Providing us with this information before your appointment and bringing in all medication(s) and/or supplements to your appointment allows you to receive the most benefit from your initial appointment.

Readiness Assessment

In order to improve your health, how willing are you to:

	Very Willing				Unwilling
Significantly modify your diet	☐5	☐4	☐3	☐2	☐1
Take several nutritional supplements each day	☐5	☐4	☐3	☐2	☐1
Keep a record of everything you eat each day	☐5	☐4	☐3	☐2	☐1
Modify your lifestyle (i.e. 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
Have periodic lab tests to assess your progress	☐5	☐4	☐3	☐2	☐1

Comments: _____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

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

If you are not confident of your ability, what aspects of yourself or your life lead you to questions your capacity to fully engage in the above activities? _____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to you implementing the above changes? ☐5 ☐4 ☐3 ☐2 ☐1

Comments: _____

_____

_____

Rate on a scale of 5 (very supportive to 1 (very unsupportive):

How much ongoing support and contact (i.e. telephone consults, e-mail correspondence) from your professional staff would be helpful to you as you implement your personal health program?
☐5 ☐4 ☐3 ☐2 ☐1

Comments: : _____

_____

_____

Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Maiden/Previous Names: _____

Full Address: _____

_____

Phone Number: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility:
_____

Address:
_____

City, State, Zip:
_____

Phone & Fax:
_____

Release Information To:

Name/Facility:
Ballen Medical

Address:
6081 S. Quebec St., Ste 100

City, State, Zip:
Centennial, CO 80111

Phone & Fax:
720-222-0550 Fax: 720-496-4948

Purpose of Release:

☐ Continuing Medical Care ☐ Work Comp ☐ Disability Determination ☐ Personal

☐ Insurance Claim ☐ Application for Insurance ☐ Other: _____

Delivery Method: **Date information desired by:** _____

Release Format (Check 1 option only):

☐ Paper via ☐ Mail **OR** ☐ Pick Up **OR** ☐ Fax *(as appropriate)* **Fax #:** _____

Information to be Released:

Service Dates: From: _____ To: _____ **OR** ☐ all future records until this authorization expires

NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*.

☐ Discharge Summary ☐ ER Records ☐ History & Physical ☐ Clinic Visit Notes

☐ Psychological Evals/Assessments FOR THIS REQUEST I AUTHORIZE RELEASE OF ANY ALCOHOL OR DRUG TREATMENT RECORDS

☐ EKG/Cardiology Reports ☐ Immunization Records ☐ UNLESS Operative Reports INDICATED BELOW:

☐ Lab / Pathology Reports ☐ Radiology Images ☐ Radiology reports ☐ Entire Medical Record

☐ Billing Statements (charges may apply)

☐ Alcohol/Drug Treatment Records _____

☐ Other: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be redisclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature *(required)* **Date Signed** (required)

BALLEN MEDICAL & WELLNESS

COLORADO RECOVERY INFUSION CENTER

Notice of Privacy Practices (HIPAA)

****This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.****

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by Ballen Medical and Wellness in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is if you are referred to a primary care doctor or another specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit. (Please note that Ballen Medical and Wellness does not submit to insurance.)
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would-be patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related enemies and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of your PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes (these are not part of your medical record under HIPAA).
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.
- Disclosures that constitute a sale of PHI under HIPAA.
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI

- The right to request restrictions in certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of the initial date of service and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Director, Elizabeth Reece, RN BSN, for more information, in person or in writing.

Receipt of Notice of Privacy Practices and Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I am a patient of Ballen Medical and Wellness. I, _____ hereby acknowledge receipt of Ballen Medical & Wellness' Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is under the age of 15)

BALLEN MEDICAL & WELLNESS

COLORADO RECOVERY INFUSION CENTER

Credit Card Authorization & Cancellation Policy

****Highlighted sections MUST be completed**

Patient Name: _____ Name on Card: _____

Credit Card Number: _____

Expiration: _____ CVV: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email address: _____

_____ I understand that payment is due at the time of service and will be collected prior to my appointment.

_____ Any outstanding balance on my account **MUST** be paid **BEFORE** scheduling the next appointment and may affect any medication refill requests. **Any returned check will be subjected to a $25 NSF fee; including the amount of the check.**

_____ In the event that my outstanding balance is not paid in full in a reasonable amount of time, I realize Ballen Medical may take further legal action as necessary to recover the amount outstanding. Should Ballen Medical find it necessary to take legal action to recover any amount due, I agree to be liable for all reasonable collection costs incurred, including but not limited to, reasonable attorneys' fees.

_____ I hereby authorize Ballen Medical to use the provided credit card information to charge my account for appointments, cancellations with less than 24 business hour notice, or no shows.

NO SHOW/LATE CANCELLATION POLICY

As you are aware, medical offices tend to be very busy and often have waiting lists for emergency cases. To better serve our patients and assure they have a fair opportunity to have an appointment as soon as possible, we ask for the following assistance:

1. If you are going to be more than 10 minutes late for an appointment, please call us to ensure that we can still work you into our schedule. There is no guarantee that we can hold your appointment, but we will do our best.

2. If you need to cancel or reschedule an appointment, please call us 24 business hours prior to your appointment. We can often get patients in who are in need of our care.

_____ I understand the importance of the 24-business hour cancellation policy and that I will be charged if Ballen Medical/Colorado Recover Infusion Center does not receive the proper notice.

_____

Signature Date

_____

Printed Name