THE IDAHO CENTER FOR INTEGRATIVE MEDICINE

3224 N. Maple Grove Rd.
Boise, ID 83704
tel: (208) 629-5374 | fax: (208) 629-5394
www.theICIM.com

New Patient Information – Fct Med

Personal:
Last Name: _____ First Name: _____ Middle Initial: ____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Cell: (____) _____ Email: _____

Birth date: _____ Sex: M / F Marital Status: M / S Social Security #: _____

Ethnicity/Race: _____ Date of Injury:_____

Emergency Contact: _____ Phone: (_____) _____

Work:
Occupation: _____ Employer: _____ Office #: _____

Primary Insurance Information:
Health Plan: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Member ID Number: _____ Group Number: _____

Do you have SECONDARY Health Insurance ? Y / N

Whom may we thank for referring you to our office? _____

Do you have a medical doctor? ____Yes _____No If yes, Doctor's name: _____

Doctor's phone number: _____ Approx date of last visit: _____

__ I understand that most insurance plans do NOT cover Functional Medicine and Nutritional consultation services, and I will therefore be responsible for all costs not covered under my plan
___ I understand there is a $35 fee for any **missed appointment** or failure to provide **notice 24+ hours in advance**
___ It is my responsibility to pay any deductible, co-insurance, and/or any other balances not covered by insurance or other third party payers. My signature indicates that I agree to pay for any outstanding bills incurred in this office.
___ I authorize that payment be made directly to my provider at the Idaho Center for Integrative Medicine for any and all insurance benefits or reimbursement for services rendered. **I also authorize release of any information concerning my health and healthcare services** to my insurance companies, Medicare, or other healthcare plans.

_____ _____
Patient Signature Date

HEALTH INFORMATION FORM

Patient name: _____ *Date*: _____

General Health Questions:

Blood Pressure_____ Weight:_____(in pounds) Height:_____(in inches)

List all Medications: _____ _____

List all Allergies (food, medication):_____

Do you currently smoke tobacco of any kind? ____Yes _____Never a smoker ____ Former smoker

If yes, how often do you smoke per day? ___ 1-3 ___ 4-10 ____ 10-20 ____ 20+

If yes, what is your level of interest in quitting smoking: 0 1 2 3 4 5 6 7 8 9 10

Has any doctor diagnosed you with Hypertension presently? ____ Yes _____No

Has any doctor diagnosed you with Diabetes presently? _____Yes _____No _____ Last A1c score

Reason for Visit:

What is your primary complaint? _____

How severe are your symptoms? **mild** 0 1 2 3 4 5 6 7 8 9 10 **severe**

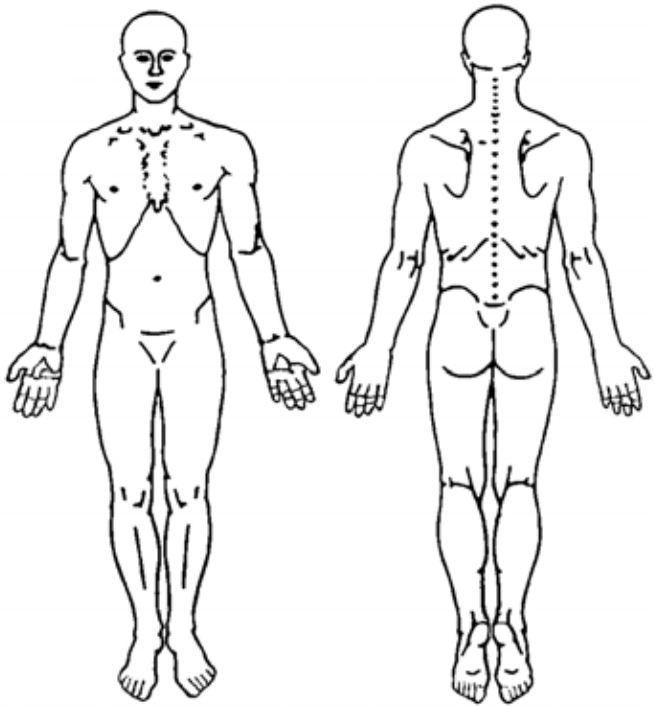
What treatment have you had for these complaints?_____

Have you had x-rays, MRI's or other tests for this condition? ____Y ____N Date:_____

Location_____ Type:_____

Please use the diagram to mark any areas you are experiencing symptoms

C= *Color change*
L=*Loss of function*
M=*Medical surgery*
N = *Numbness*
O=*Other*
P = *Pain*
R= *Rash*
S= *Swelling*
T = *Tingling*
X= *Scar*



Consent to Treat and Authorization to Release Information

The undersigned consents to examination which may include physical, orthopedic, neurological, laboratory, and radiographic as needed to evaluate and or diagnose the patient.

The undersigned also consents to therapeutic procedures as are deemed necessary by their doctor in the course of treatment. These therapeutic procedures may include any of the following: Spinal and extra spinal manipulation/adjustments, ice, heat, electrical muscle stimulation, ultrasound, soft tissue manipulation, taping, exercise, nutritional supplementation, minor surgery, intravenous therapy, stitching, and any other procedures as prescribed by the doctor.

The doctors and staff make every effort within their power to minimize risks involved in any procedure. In spite of that, there may be a very small risk of complications. You are encouraged to ask questions, and your signature implies that you understand your risks and alternatives to recommended treatments.

I have read the above information, and by my signature, give my consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline any procedure I am not completely comfortable with.

I hereby provide authorization for the provider and staff to complete insurance claims as I may request, and understand that records will be held in confidence and not released for any other purpose.

____ **(initials)** I have been given the HIPAA form to review, and I agree to its contents.

_____ _____

Patient Date

_____

Signature

_____ _____

Signature of Parent (if Minor) Date

ICIM FINANCIAL POLICY

In Order to avoid any misunderstanding, the ICIM provides the following financial policies:

General:

All accounts are due and payable upon receipt of a mailed patient statement unless other arrangements are made at the time of service. Deductibles and co-pays are due at the time of service.

Accounts over 30 days of the first mailed statement will accrue a finance charge of 1.5% per month or 18% per year. Any and all accounts owing over 90 days may be turned over to a collection agency and may accrue a finance charge at the rate of 2% per month or 24% per year.

A $35.00 returned check charge will be added to all returned checks.

The Idaho Center for Integrative Medicine (ICIM) has one set fee schedule; however the amount that patients are responsible for will vary depending on their benefit coverage. If patients do not have private health insurance, Medicaid, Medicare, or other covered benefit plan, they are entitled to a "Time of Service" discount. Under this discount plan, payments are expected the same day the service was performed, and in exchange for prompt payments, the ICIM will offer 10-20% discounts depending on applicable laws (the government restricts the amount that can be discounted legally). The exact discount can be determined at the front office. Under certain circumstances, financial hardship plans are accepted by the ICIM, and if you feel as though your financial circumstances are such that you may require discounts beyond the customary Time of Service discounts, please inquire options at the front office. A Financial Hardship Form must be signed in these cases.

Health Insurance:

Your insurance is a contract between you and the insurance company. For your convenience, we will be happy to submit your charges to your insurance company. Not all services are a covered benefit in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Work Comp:

If you are involved in a work-related injury, your employer and/or worker's comp insurance policy is responsible for the cost of care. You will not receive a bill once the insurance carrier/employer has accepted the claim. You are responsible for creating the claim with your employer, and the claim number will be needed in order to receive treatment in our office.

Auto Injury:

If you are injured in a motor vehicle accident, we will submit claims to your own auto insurance even if you are not at fault. If you have Med Pay on your auto insurance, your treatment is covered until the Med pay runs out or treatment is finished. Your Med Pay carrier is responsible to pay over the course of care, while the insurance of the liable party will only pay at the time of settlement. When your Med Pay is exhausted we may submit claims to your group health carrier or make other arrangements with you. You may be asked to sign an Assignment Agreement so we can submit bills to your auto insurance and/or attorney and receive payments directly from them. Even if you are not at fault in an accident, there is no guarantee that treatment rendered in this office will be covered, and you are personally responsible for all charges incurred in the office.

Medicare, Medicaid:

We accept patients with Medicare and/ or Medicaid coverage. These programs provide limited coverage and do not pay for commonly used procedures in this clinic including myofascial release, exercises, PT modalities, and examinations. Medicare patients are responsible for deductibles, co-pays and all of these non-covered services. Medicare patients are required to fill out an Advanced Beneficiary Notice (ABN) form that will show the costs of the common non-covered services. Medicaid patients are responsible for non-covered services, but are not responsible for deductibles or co-pays.

My signature indicates I have read and understand this financial policy.

Signature: _____ Date: _____

FAMILY HISTORY: For each member of your family, please check the boxes for:
1. Their present state of health, and
2. Any illnesses they have had.

PRINT NAMES BELOW	Good Health	Poor Health	Deceased	Age and cause of death	Alcoholism	Allergies/Asthma/Eczema	Alzheimer's/Dementia	Anemia	Arthritis	Auto-immune (see LIST)	Blood Clotting	Diabetes	Cancer/Tumor	Epilepsy	Genetic Disease	Heart Disease	High Blood Pressure	Intestinal/Bowel Disorders	Kidney Bladder Disease	Liver Disease	Mental Disorders	Osteoporosis	Stroke	Thyroid Disease	Ulcers in GI tract
Father:																									
Mother:																									
Siblings:																									
Spouse:																									
Children:																									
Paternal relatives (write # of relatives affected in each box):																									
Maternal relatives (write # of relatives affected in each box):																									

CIRCLE ANY Autoimmune Diseases that run in your Family - Alopecia, ALS, Ankylosing Spondylitis (AS), Crohn's, dermatomyositis, diabetes (type 1), Juvenile idiopathic arthritis, glomerulonephritis, Graves' disease, Guillain-Barré, Hashimoto's, Idiopathic thrombocytopenic purpura, Lichen planus, Lupus, Myasthenia gravis, Multiple Sclerosis (MS), Pemphigus, Pernicious anemia, Polyarteritis nodosa, Polymyositis, Biliary cirrhosis, Psoriasis, Rheumatoid arthritis, Scleroderma, Sjögren's, Uveitis, Ulcerative Colitis Vitiligo, Wegener's, Other: _____

Dr. Noah Edvalson, DC, NMD, CCSP, FIAMA, FAAO
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Functional Health Assessment Form

Name: _____ Age: _____ Sex: ____ Date: _____

Occupation: _____ TOTAL FHA SCORE_____

PART I:

Please list the 5 major health concerns in **your order of importance**:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any conditions you have been previously diagnosed with by another physician:

1. _____Date_____
2. _____Date_____
3. _____Date_____
4. _____ Date _____
5. _____Date_____

Please list ALL surgeries you've had in your life (include C-sections, Cosmetic, Hernias, Dental, etc...):

1. _____Reason_____ Mo/Yr_____
2. _____Reason_____ Mo/Yr_____
3. _____Reason_____ Mo/Yr_____
4. _____Reason_____ Mo/Yr_____
5. _____Reason_____ Mo/Yr_____

Please list any Rx medications you currently take and for what conditions:

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

Please list any significant results of any lab, x-ray, MRI, CT, or other recent studies:

1. _____Date_____
2. _____Date_____
3. _____Date_____
4. _____Date_____
5. _____Date_____

Please list any natural supplements you currently take and for what conditions:

1. _____Condition_____
2. _____Condition_____
3. _____Condition_____
4. _____Condition_____
5. _____Condition_____
6. _____Condition_____

PART II:

Please choose the appropriate number "0 - 4" on all questions below.

0 = the least/never 4 = the most/always.

Category I	Least/Never	0	1	2	3	4	Most/Always
Feeling that bowels do not empty completely							
Lower abdominal pain relieved by passing stool or gas							
Diarrhea (loose stool, not formed)							
Constipation (strain to have BM, or small/hard pieces)							
Hard, dry, or small stool							
Coated tongue or "fuzzy" debris on tongue							
Pass large amount of foul smelling gas							
More than 3 bowel movements daily							
Use laxatives frequently							
	TOTAL SCORE						

Category II	Least/Never	0	1	2	3	4	Most/Always
Excessive belching, burping, or bloating							
Gas immediately following a meal							
Offensive breath							
Difficult bowel movements							
Sense of fullness during and after meals							
Difficulty digesting fruits and veggies; undigested foods in stools							
	TOTAL SCORE						

Category III	Least/Never	0	1	2	3	4	Most/Always
Stomach pain, burning, or aching 1- 4 hours after eating							
Use of antacids							
Feeling hungry an hour or two after eating							

Heartburn when lying down or bending forward						
Temporary relief from heartburn with antacids, food, milk, carbonated beverages						
Digestive problems subside with rest and relaxation						
Heartburn w/ spicy, chocolate, citrus, peppers, alcohol, or caffeine						
TOTAL SCORE						

Category IV	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Roughage and fiber cause constipation							
Indigestion and fullness lasts 2-4 hours after eating							
Pain, tenderness, soreness on left side under rib cage							
Excessive passage of gas							
Nausea and/or vomiting							
Stool undigested, foul smelling, mucous, greasy, or poorly formed							
Frequent urination							
Increased thirst and appetite							
Difficulty losing weight							
TOTAL SCORE							

Category V	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Greasy or high fat foods cause symptoms							
Lower bowel gas and or bloating several hours after eating							
Bitter metallic taste in mouth, especially in the morning							
Unexplained itchy skin							
Yellowish cast to eyes							
Stool color alternates from clay colored to normal brown							
Reddened skin, especially palms							
Dry or flaky skin and/or hair							
History of gallbladder attacks or stones							
TOTAL SCORE							

Have you had your gallbladder removed? **Yes** ___ **No** ___

Category VI	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Crave sweets during the day							
Irritable if meals are missed							
Depend on caffeine to keep yourself going or started							
Get lightheaded if meals are missed							
Eating relieves fatigue							
Feel shaky, jittery, tremors							
Agitated, easily upset, nervous							
Poor memory, forgetful							
Blurred vision							
TOTAL SCORE							

Category VII	Least/Never	0	1	2	3	4	Most/Always
Fatigue after meals							
Crave sweets during the day							
Eating sweets does not relieve cravings for sugar							
Must have sweets after meals							
Waist girth is equal or larger than hip girth							
Frequent urination							
Increased thirst & appetite							
Difficulty losing weight							
TOTAL SCORE							

Category VIII	Least/Never	0	1	2	3	4	Most/Always
Cannot stay asleep							
Crave salt & sugar							
Slow starter in the morning							
Afternoon fatigue							
Weak immune system (susceptible to cold/flu)							
Dizziness when standing up quickly							
Afternoon headaches							
Headaches with exertion or stress							
Weak nails							
TOTAL SCORE							

Category IX	Least/Never	0	1	2	3	4	Most/Always
Cannot fall asleep							
Perspire easily							
Under high amounts of stress							
Weight gain when under stress							
Wake up tired even after 6 or more hours of sleep							
Excessive perspiration with little to no activity or exercise							
TOTAL SCORE							

Category X	Least/Never	0	1	2	3	4	Most/Always
Tired, sluggish							
Feel cold – hands, feet, all over							
Require excessive amounts of sleep to function properly							
Increase in weight gain even with low-calorie diet							
Gain weight easily							
Difficult, infrequent bowel movements							
Depression, lack of motivation							
Morning headaches that wear off as the day progresses							
Outer third of eyebrow thins							
Thinning of hair on scalp, face or genitals or excessive falling hair							
Dryness of skin and/or scalp							
Mental sluggishness							
TOTAL SCORE							

Category XI	Least/Never	0	1	2	3	4	Most/Always
Heart palpitations							
Inward trembling							
Increased pulse even at rest							
Nervous and emotional							
Insomnia							
Night sweats							
Difficulty gaining weight							
	TOTAL SCORE						

Category XII	Least/Never	0	1	2	3	4	Most/Always
Urination difficulty or dribbling							
Urination frequent							
Pain inside of legs or heels							
Feeling of incomplete bowel evacuation							
Leg nervousness at night							
	TOTAL SCORE						

MALES ONLY - Category XIII	Least/Never	0	1	2	3	4	Most/Always
Decrease in libido							
Decrease in spontaneous morning erections							
Decrease in fullness of erections							
Difficulty in maintain morning erections							
Spells of mental fatigue							
Inability to concentrate							
Episodes of depression							
Muscle soreness							
Decrease in physical stamina							
Unexplained weight gain							
Increase in fat distribution around chest and hips							
Sweating attacks							
More emotional than in the past							
	TOTAL SCORE						

Menstruating Females ONLY - Category XIV	Least/Never	0	1	2	3	4	Most/Always
Pain and cramping during periods							
Scanty blood flow							
Heavy blood flow (1+ hygiene product ea. 1-2 hrs)							
Breast pain and swelling during menses							
Pelvic pain during menses							
Anxiety/depression/mood swings around period							
Acne break outs							
Facial hair growth							
Hair loss/thinning							
Extended menstrual cycle (greater than 32 days)							
Shortened menses (less than every 24 days)							
	TOTAL SCORE						

Post Menopausal Women ONLY - Category XV	Least/Never	0	1	2	3	4	Most/Always
Hot flashes							
Mental fogginess							
Disinterest in sex							
Mood swings							
Depression							
Painful intercourse							
Shrinking breasts							
Facial hair growth							
Acne							
Increased vaginal pain, dryness or itching							
	TOTAL SCORE						

How many years have you been menopausal ___

Since menopause, do you ever have uterine bleeding **Yes** ___ **No** ___

Are you having alternating menstrual cycle lengths? **Yes** ___ **No** ___

<u>PART III</u>: Neurotransmitter Assessment

Section Brain	Least/Never	0	1	2	3	4	Most/Always
Is your memory noticeably declining							
Are you having a hard time remembering names or phone numbers							
Is your ability to focus noticeably declining							
Has it become harder for you to learn things							
How often do you forget about your appointments							
Is your temperament getting worse in general							
Are you losing your attention span endurance							
How often do you find yourself down or sad							
How often do you fatigue when driving compared to the past							
How often do you fatigue when reading compared to the past							
How often do you walk into rooms and forget why							
How often do you pick up your cell phone and forget why							
	TOTAL SCORE						

Section S	Least/Never	0	1	2	3	4	Most/Always
Are you losing your pleasure in hobbies and interests							
How often do you feel overwhelmed with ideas to manage							
How often do you have feelings of inner rage (anger)							
How often do you have feelings of paranoia							
How often do you feel sad of down for no reason							
How often do you feel like you are not enjoying life							
How often do you feel you lack artistic appreciation							
How often do you feel depressed in overcast weather							
Are you losing your enthusiasm for your favorite activities							
How much are you losing enjoyment for your favorite foods							

Are you losing your enjoyment of friendships and relationships						
How often do you have difficulty falling into deep restful sleep						
How often do you have feelings of dependency on others						
How often do you feel more susceptible to pain						
How often do you have feelings of unprovoked anger						
TOTAL SCORE						

Section D	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
How often do you have feelings of hopelessness							
How often do you have self-destructive thoughts							
How often do you have an inability to handle stress							
How often do you have anger and aggression while under stress							
Do you feel you are not rested even after long hours of sleep							
How often do you prefer to isolate yourself from others							
Do you have unexplained lack of concern for family and friends							
How easily are you distracted from finishing tasks							
How often do you feel the need to consume caffeine to stay alert							
How often do you feel your libido has been decreased							
How often do you lose your temper for minor reasons							
How often do you have feelings of worthlessness							
TOTAL SCORE							

Section G	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Do you feel anxious or panic for no reason							
Do you have feelings of dread or impending doom							
Do you feel knots in your stomach							
Do you have feelings of being overwhelmed for no reason							
Do you have feelings of guilt about everyday decisions							
Does your mind feel restless							
How difficult is it to turn your mind off when you want to relax							
Do you have disorganized attention							
Do you worry about the things you were not worried about before							
Do you have feelings of inner tension and inner excitability							
TOTAL SCORE							

Section ACH	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Do you feel your visual memory (shapes & images) is decreased							
Do you feel your verbal memory is decreased							
Do you have memory lapses							
Has your creativity been decreased							
Has your comprehension been diminished							
Do you have difficulty calculating numbers							
Do you have difficulty recognizing objects and faces							
Do you feel like your opinion about yourself has changed							
Are you experiencing excessive urination							

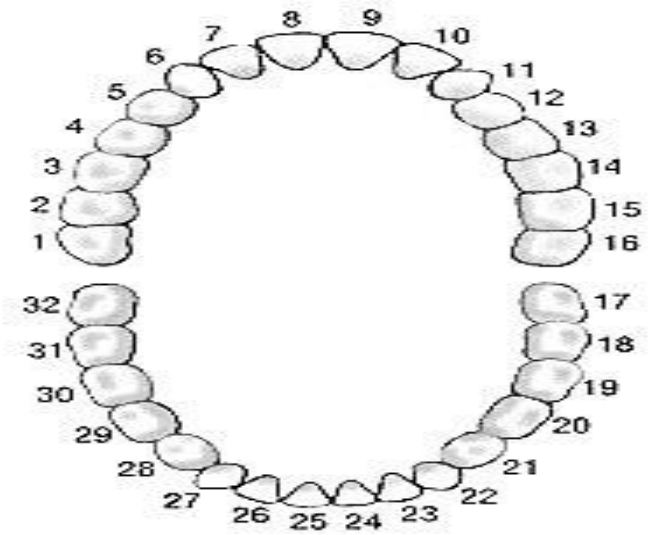
Are you experiencing slower mental response					

TOTAL SCORE

PART IV: **DENTAL**

Use the diagram below to show placement	**Y**	**N**	**?**	**Past**
Do you currently have amalgam "silver" fillings ? How Many? ____				
Have you removed or changed any dental amalgam fillings/crowns?				
Did you have amalgam fillings as a child? How Many? ____				
Do you have any **root canal** treated teeth? How Many? _____				

Please mark and label the locations of any fillings or root canals:



A = Amalgam

GC = Gold Crown
PC = Porcelain Crown
PD = Periodontal Dz
RC = Root Canal
EX = Extraction
AW= AbN Wear
I = Implant

PART V: NUTRITION

Diet:

How many servings of vegetables do you eat per day? _____
How many times per week do you workout? _____
List the three worst foods you eat during the average week: _____,
_____, _____
List the three healthiest foods you eat during the average week: _____,
_____, _____
Do you smoke?_____ If yes, how many times a day: _____
Rate your stress levels on a scale of 1-10 during the average week: _____
What is the primary source of your stress? _____

How often do you consume (per week):	**Never**	**0**	**1-3**	**4-6**	**7-10**	10+
Fish (fresh, frozen, canned, ect.)?						
Organic and pasture fed animal products?						
Organic produce?						
Artificial sweeteners: NutraSweet, Equal, Aspartame, Splenda?						

Alcohol?					
Sugary sweets (candy, ice cream, cake, donuts, etc…)					
Deep fat fried foods?					
Caffeinated beverages					
Sodas, juices, drinks containing High Fructose Corn Syrup					

PART VI: TOXIN EXPOSURE

Have you been exposed to any of these in the last 12 months?	**Y**	**N**	**?**	**Past**
Renovations (new carpets; add ons; ect.)?				
Water leaks (ceilings, walls, floors) OR Visible MOLD?				
Crumbling walls, ceiling, insulation, or paint?				
Regular contact with gas, propane, coal, or wood stove?				
Regular contact with smokers?				
Pesticides or herbicides?				
Harsh chemicals (varnish, glue, gas, acid, cleaners, etc...)?				
Welding or soldering?				
Metals (Lead, Mercury, ect.)?				
Paints?				
Photo developing / Dark room?				

PART VII: SLEEP

Have you ever been told that you snore at night?	Never	Sometimes	Often
Has it ever been reported to you that you stop breathing or gasp during sleep?	Never	Sometimes	Often
Have you ever been treated for high blood pressure?	YES		NO

Do you occasionally fall asleep during the day when:

You are busy or active?	Never	Sometimes	Often
You are driving or stopped at a light?	Never	Sometimes	Often

	What is your collar size?	**(Circle one)**
Male:	Less than 17 inches	More than 17 inches
Female:	Less than 16 inches	More than 16 inches

How motivated are you to make changes to improve your health?

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Not very, I just want info---------->Somewhat ---------->Very, I will do anything you ask

Is there anything else about your health or history that you think is important, which we have not asked thus far?