**Patient Demographics**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment: \_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to leave voicemail? YES NO Consent to email? YES NO

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT INFORMATION**

Patient Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISTRICT EMPLOYEE INFORMATION**:

Employers District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of The Privacy Practices/HIPAA**

The privacy practice is/was provided so that I can make an informed decision whether to allow release of the information.

I understand that I do not have to sign this authorization in order to receive treatment from Consiglio Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Consiglio Wellness Center

1501 NW Jefferson St

Blue Springs, MO 64015-7242

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient** or Legal Guardian **Relationship to Patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Patient’s Name** **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient’s Legal Guardian (if applicable)

I authorize the staff at Consiglio Wellness Center to release health information to the following individual(s) or medical practice(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medical Practice Name/Provider Name Fax Number

**Patient Medical History**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental/Other Allergies: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant: Yes No Breastfeeding: Yes No Last Menstrual Period: \_\_\_\_\_\_\_\_\_

Current Medications (prescription, over-the-counter, vitamins, supplements)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose/Strength | Medication | Dose/Strength |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Past Medical History (make an X next to conditions you currently have or have had in the past)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | Current | Past | Condition | Current | Past |
| Heart Disease |  |  | High Blood Pressure |  |  |
| High Cholesterol |  |  | Liver Disease |  |  |
| Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Anemia/Blood Disorder |  |  |
| Diabetes: Type \_\_\_\_\_\_\_\_ |  |  | Thyroid Disease |  |  |
| Stroke |  |  | Seizures |  |  |
| Headaches/Migraine |  |  | TB (Tuberculosis) |  |  |
| Mental Health Disorder  (Anxiety/Depression/Bipolar/PTSD) |  |  | Nerve Impairment |  |  |
| Spinal Disorder |  |  | Sleep Apnea |  |  |
| Lung Disease (Asthma/COPD) |  |  | Chronic Skin Condition |  |  |
| GI Disorder (Reflux/Heartburn) |  |  | Kidney/Bladder Prostate |  |  |
| Other Conditions: |  |  |  |  |  |

Surgical History

|  |  |
| --- | --- |
| Surgery | Approximate Date |
|  |  |
|  |  |
|  |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Family History   
 No known family history

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Condition | Mother | Father | Sister | Brother | Daughter | Son |
| Heart Disease |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |
| Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| Diabetes: Type \_\_\_\_\_\_\_ |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Headaches/Migraine |  |  |  |  |  |  |
| Mental Health Disorder  (Anxiety/Depression/Bipolar) |  |  |  |  |  |  |
| Spinal Disorder |  |  |  |  |  |  |
| Lung Disease (Asthma/COPD) |  |  |  |  |  |  |
| GI Disorder (Reflux/Heartburn) |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |
| Anemia/Blood Disorder |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |
| TB (Tuberculosis) |  |  |  |  |  |  |
| Nerve Impairment |  |  |  |  |  |  |
| Sleep Apnea |  |  |  |  |  |  |
| Chronic Skin Condition |  |  |  |  |  |  |
| Kidney/Bladder Prostate |  |  |  |  |  |  |
| Deceased/Age at Death |  |  |  |  |  |  |
| Other Conditions: | | | | | | |

Social History

**Tobacco/Drug Use:**  
Do you smoke cigarettes? Y N Current: \_\_\_\_\_ packs per day \_\_\_\_ # of years

Are you a previous smoker? Y N Chew Tobacco? Y N

Do you smoke marijuana? Y N Use a vaping device? Y N   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use:**  
Do you drink alcohol? Y N Beer Wine Liquor  
\_\_\_\_\_\_\_# of drinks per week  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­­­­­­­­­ **Caffeine Use:**  
Do you drink caffeine? Y N \_\_\_\_\_\_\_\_\_ cups per day