Holistic Family Care
1215 E. Livingston St. Orlando, FL 32803
Tel: 407-885-8255 Email: info@holisticfamily.care

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

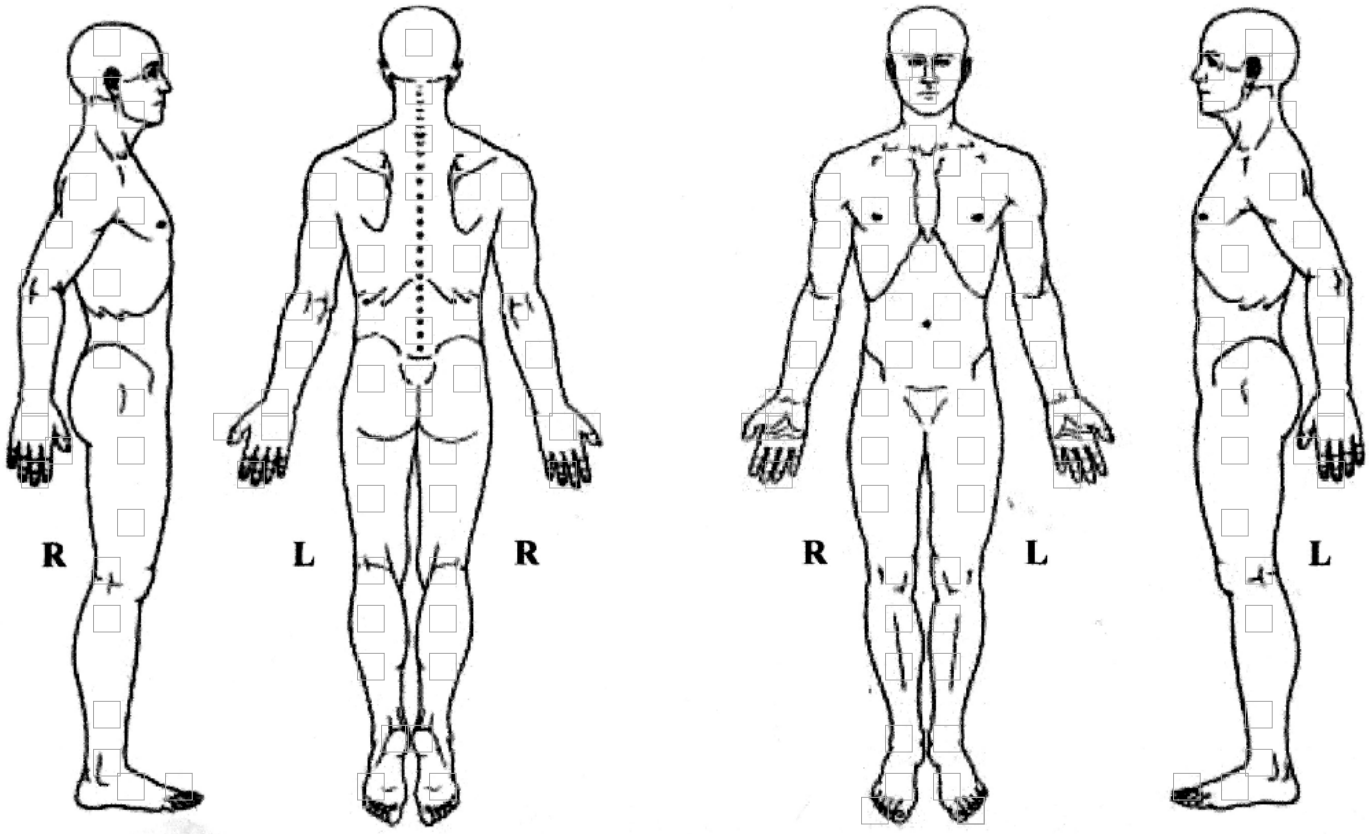
CURRENT CONDITION, WHAT BRINGS YOU TO OUR OFFICE TODAY? List in order of severity.

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

Last Name | First Name | Date

Signature

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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

Last Name First Name Date

Signature

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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

◯ ☐ Vision 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	◯ ☐ Diabetes	◯ ☐ 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	◯ ☐ Vomiting

Last Name | First Name | Date | Signature

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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

How many pregnancy delivered? ☐ How many miscarriage? ☐ What age was first menstrual cycle? ☐

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	
Osteoporosis		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

Last Name | First Name | Date

Signature

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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.

Last Name | First Name | Date

Signature

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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.

Holistic Family Care 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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Print Form

Patient Privacy Form

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

CHANGE OF OWNERSHIP
In the event that Holistic Family Care 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 Holistic Family Care 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 Holistic Family Care LLC amend your protected health information. Please be advised, however, that Holistic Family Care 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 Holistic Family Care 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
Holistic Family Care 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, Holistic Family Care LLC is required by law to comply with this notice.

Holistic Family Care 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: Holistic Family Care LLC by calling this office at 407-885-8255. If Holistic Family Care 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 Holistic Family Care LLC has handled your health information should be directed to Holistic Family Care LLC by calling this office at 407-885-8255. If Holistic Family Care 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 Holistic Family Care 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 _____

PATIENT AGREEMENT

THIS is made this ____ day of _____, 202__, between HOLISTIC FAMILY CARE, LLC, a Florida limited liability company ("HOLISTIC FAMILY CARE"), and _____ ("Patient").

The Patient has sought treatment or other services from the staff of HOLISTIC FAMILY CARE. It is agreed that the following terms and conditions govern all aspects of the relationship between the Patient and HOLISTIC FAMILY CARE.

1. **OBLIGATIONS OF HOLISTIC FAMILY CARE.** HOLISTIC FAMILY CARE shall provide services to the Patient consistent with the agreed treatment plan developed between them. HOLISTIC FAMILY CARE agrees that all services provided by it and its staff shall be delivered in a manner consistent with the licenses and regulations applicable to the services and with prevailing applicable professional standards in the Orlando, Florida, area. HOLISTIC FAMILY CARE further agrees at all times to treat the Patient with care for the Patient's physical and emotional well-being and to respect the privacy of the Patient and all information provided by the Patient to HOLISTIC FAMILY CARE. Any questions or concerns expressed by the Patient shall be promptly and fully responded to by the individuals responsible for the services provided to the Patient.

2. **OBLIGATIONS OF THE PATIENT.** The Patient shall communicate openly with HOLISTIC FAMILY CARE regarding the Patient's concerns and expectations for the potential benefit of the services to be provided by HOLISTIC FAMILY CARE. The Patient understand and agrees that the HOLISTIC FAMILY CARE cannot and does not guarantee that any specific result will follow from the services to be provided. The Patient recognizes that risks are associated with any form of services applied to the body, including without limitation the risk of injury and permanent disability. The Patient knowingly accepts such risk and agrees to release and hold HOLISTIC FAMILY CARE, its staff, managers and members, harmless from any and all loss, liability, cost, damage and attorneys fees incurred by the Patient arising out of the provision of the services by HOLISTIC FAMILY CARE.

In addition, the Patient has provided to HOLISTIC FAMILY CARE digitally recorded or transmitted information and agreements as reflected on the Patient Forms page of www.holisticfamily.care. The Patient represents that his or her responses to the patient information and agreement to the terms and conditions contained in the Patient Forms are accurate and complete and may be relied upon by HOLISTIC FAMILY CARE and its staff in the formulation and implementation of a treatment plan and delivery of services to or for the Patient.

3. **PAYMENT FOR SERVICES.** To the extent that the services provided or to be provided are not covered by insurance, the Patient agrees to pay for such services in advance or at such time as the Patient receives a statement for the services by HOLISTIC FAMILY CARE.

4. **GENERAL PROVISIONS**.

A. This Agreement shall be binding upon the heirs, executors, administrators, successor(s) and assigns of all parties.

B. Modification. This Agreement may be amended or modified only by written Agreement signed by both parties.

C. Partial Invalidity. If any provision of this Agreement shall be invalid or unenforceable, the remainder of this Agreement shall not be affected thereby and each provision of this Agreement shall be valid and in force to the fullest extent permitted by law.

D. Florida Law Governs; Venue. The laws of the State of Florida shall govern this Agreement in all its aspects, including execution, interpretation, performance and enforcement. The parties hereto consent and by the execution hereof, submit themselves to the jurisdiction of the courts of the State of Florida for any litigation arising from this Agreement. Venue for any proceeding involving this Agreement shall be only in Orange County, Florida.

E. Entire Agreement. This Agreement constitutes the entire Agreement between the parties with respect to the subject matter hereof, and there are no other representations, warranties, or Agreements except as herein provided.

F. No Presumption. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted, it being understood that the terms and provisions hereof have been negotiated at arms' length.

Please check one of the following: ☐ It is permissible to call and/or leave a detailed message.

☐ DO NOT CALL

PATIENT

Signature: _____

Printed Name: _____

HOLISTIC FAMILY CARE, LLC

Signature: _____

Staff Print Name: _____