

Patient Name: _____

Date: _____



CANTERBURY
WELLNESS CENTER

4500 E. 9th Avenue
Suite 640
Denver, CO. 80220

Margaret Eagan, M.D.
Kate Johnson, N.P.-C

Patient Information (Please Print Clearly)

Last name: _____ First Name: _____ Middle Initial: _____

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

Date of Birth: ____/____/____ Social Security #: ____/____/____ Male Female

Home Phone: ____ -- ____ -- ____ Cell Phone: ____ -- ____ -- ____ Marital Status: _____

Email: _____ Work Phone: ____ -- ____ -- ____

Insurance Co: _____ Policy Holder ID#: _____

Policy Holder: _____ Insurance Phone: ____ -- ____ -- ____

Policy Holder Date of Birth: ____/____/____ Who Referred you: _____

Emergency Contact: _____ Emergency Contact Daytime Phone: ____ -- ____ -- ____

Primary Care Physician: _____ Doctor's Phone #: ____ -- ____ -- ____

Financial Responsibility:

Co-payments & any balances are due at the time of service. I agree to be personally and fully responsible for payment of all services rendered in accordance with my insurance benefits and for non-covered services. Your insurance is your responsibility. Know your benefits before each office visit. We cannot bill your insurance appropriately unless you provide all of your insurance information including your identification cards. If your insurance company denies payment, you will be responsible for the balance of the account.

I hereby authorize the providers at Canterbury Wellness Center in charge of the care of the above named patient to provide all necessary treatment for my condition(s). I verify the accuracy of the above information and authorize the release of any medical information necessary for my treatment and payment for services rendered.

Signature: _____ Date: ____/____/____

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Patient Name: _____

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**Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment or Healthcare Operations**

I, _____, understand that as a part of my health care, Canterbury Wellness Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

I understand that Canterbury Wellness Center is not required to agree to the restrictions requested. I understand that I may revoke this consent I writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Canterbury Wellness Center reserves the right to change their notice and practices and will always make available as well as post in the office, the most current copy of their privacy practices.

I understand as part of this organizations treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail.

I fully understand and accept the terms of the consent to the use and disclosure of Health Information for treatment, payment or healthcare operations. I acknowledge that I have received the Notice of Privacy Practices for Canterbury Wellness Center.

At times, the physician, administrative or medical staff will need to contact you either by phone, e-mail, fax or in writing. Unless you advise our office in writing that you do not want to be contacted we will:

- Leave detailed messages at your home, business or mobile phones about appointments, medical treatment, test results and billing issues.
- Mail, fax or e-mail appointment reminders, test results, statements and general information about the practice.

Patient Signature (Guardian if under 18 years of age)

Date

The following are authorized Family/Friends that are allowed Private Health Information concerning my condition(s):

Name

Relationship

Date

Name

Relationship

Date

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Are you allergic to any medications or foods? List anything you've had allergic reactions to and briefly explain:

List all medications you currently take and the strength and dosage (how much and how often you take each):

What is your chief complaint today? List your symptoms and how long this has been going on:

How do you feel your health compares to that of others your age?

Better Similar Worse Much Worse Unsure

How do you feel your lifestyle compares to that of others your age?

Better Similar Worse Much Worse Unsure

List all surgeries you have had and the approximate date you had them:

Do you do any of the following: (if yes, please give details)

Smoke Yes No _____

Exercise Yes No _____

Use Alcohol Yes No _____

Use Drugs Yes No _____

Diet Yes No _____

Have you been vaccinated for: (if yes, please give details)

Tetanus Yes No _____

Hepatitis B Yes No _____

Hepatitis A Yes No _____

Pneumonia Yes No _____

Influenza Yes No _____

Do you get annual Flu shots? Yes No

Family History

Please give the following health information and history. Note who in your family has ever had any of these conditions.

Thyroid Problems Yes No _____

Diabetes Yes No _____

Osteoporosis Yes No _____

Cancer Yes No _____

Asthma/ Allergies Yes No _____

Heart Disease Yes No _____

Stroke Yes No _____

High Blood Pressure Yes No _____

High Cholesterol Yes No _____

Depression Yes No _____

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Review of systems: Please answer all questions. Mark whether current or past problem and dates:

Respiratory

Pneumonia	Yes	No	_____
Tuberculosis	Yes	No	_____
Asthma	Yes	No	_____
Hay Fever	Yes	No	_____
Emphysema	Yes	No	_____
Cough up Blood	Yes	No	_____
Bring up Sputum	Yes	No	_____
Abnormal Chest x-ray	Yes	No	_____

When was your last chest x-ray? _____

Have you had a TB test? What were the results? _____

Circulatory

Heart Trouble	Yes	No	_____
Heart Murmur	Yes	No	_____
Heart Attack	Yes	No	_____
High Blood Pressure	Yes	No	_____
Rheumatic Fever	Yes	No	_____
Heart Failure	Yes	No	_____
Abnormal EKG	Yes	No	_____
Swollen Ankles	Yes	No	_____
High Cholesterol	Yes	No	_____

Endocrinology

Hormone Problems	Yes	No	_____
Thyroid Problems	Yes	No	_____
Diabetes	Yes	No	_____
Osteoporosis	Yes	No	_____
Osteopenia	Yes	No	_____

Digestive

Trouble Swallowing	Yes	No	_____
Heartburn	Yes	No	_____
Nausea or Vomiting	Yes	No	_____
Abdominal Pain	Yes	No	_____
Constipation	Yes	No	_____
Diarrhea	Yes	No	_____
Ulcers	Yes	No	_____
Hiatal Hernia	Yes	No	_____
Vomiting Blood	Yes	No	_____
Liver Problems	Yes	No	_____
Gallbladder Trouble	Yes	No	_____
Colitis	Yes	No	_____
Diverticulitis	Yes	No	_____
Black or Tarry Stole	Yes	No	_____
Bloody Stole	Yes	No	_____
Hemorrhoids	Yes	No	_____
Do you drink milk	Yes	No	_____

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Do you use laxatives Yes No _____

Other digestive issues Yes No _____

Joints

Muscle Pain Yes No _____

Back Pain Yes No _____

Disk Problems Yes No _____

Sciatica Yes No _____

Joint Pain Yes No _____

Joint Swelling Yes No _____

Gout Yes No _____

Rheumatoid Arthritis Yes No _____

Osteoarthritis Yes No _____

Urinary

Kidney Disease Yes No _____

Protein in your urine Yes No _____

Blood/Pus in urine Yes No _____

Kidney Stones Yes No _____

Kidney Infection Yes No _____

How often do you get up at night to urinate? _____

Do you ever have discomfort while urinating? _____

Have you ever had an x-ray of your kidneys? _____

Sexual & Reproductive

Are you sexually active Yes No _____

Are you?

Heterosexual Yes No _____

Homosexual Yes No _____

Bisexual Yes No _____

Men only

Non-specific Urethritis Yes No _____

Prostate Trouble Yes No _____

Do you routinely examine your testicles? _____

Women Only

Breast lumps or cysts Yes No _____

Mammogram Yes No _____

Do you regularly examine your breasts? _____

How many times have you been pregnant? _____

How many live births? _____

Do you ever bleed or spot between periods or after intercourse? _____

At what age did you begin menstruation? _____

Have you had a hysterectomy, if yes when? _____

Were your ovaries removed? _____

Are you taking birth control pills, if yes what kind? _____

If not what contraception do you use? _____

When was your last pelvic exam, and what were the results? _____

If you are still menstruating, when was your last period? _____

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Date of the period before that? _____

How many days do your periods last? _____

Are your periods regular? _____

Have you ever had a pelvic infection, if yes what was it? _____

Have you ever had a sexually transmitted disease, if yes what? _____

Have you ever had an abnormal pap smear? _____

Have you ever been sexually or physically abused? _____

Do you ever have severe PMS? _____

If you are past menopause, when was your last period? _____

Have you bled since? _____

Are you taking replacement estrogen? _____

Did you ever take replacement estrogen? _____

Have you been taking calcium supplements since menopause? _____

Hematology

Anemia Yes No _____

Bleeding Tendencies Yes No _____

Cancer Yes No _____

Neurological

Frequent headaches Yes No _____

Convulsions or Seizures Yes No _____

Neurological Disease Yes No _____

A head injury Yes No _____

Stroke or Paralysis Yes No _____

Difficulty w/ coordination Yes No _____

Difficulty Walking Yes No _____

Difficulty Speaking Yes No _____

Double Vision Yes No _____

Numbness Yes No _____

Hallucinations Yes No _____

Severe Depression Yes No _____

Severe Nervousness Yes No _____

Crying Spells Yes No _____

Difficulty with Memory Yes No _____

Anorexia or Bulimia Yes No _____

Special Senses

Glaucoma Yes No _____

Other Eye Disease Yes No _____

Deafness Yes No _____

Tinnittis or Ear noises Yes No _____

Skin

Hives Yes No _____

Rashes Yes No _____

Acne Yes No _____

Psoriasis Yes No _____

Moles or warts Yes No _____

Do you have any other skin issues? _____

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