CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: ________________________________/____________________________/__________
(Last Name) (First Name) (Middle Initial)

Preferred Name: ______________ Age: _____ Date of Birth: ___________ S.S.#: ___________________

Address:____/___________/_______/______________
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)_____________/_(____)__________________/_(____)____________________
(home) (work) (cell phone or other)

E-mail address: ____ Gender: female _____ male _____

Are you (check one): Single ____ Married ____ Other ____ Partner's Name: ___________________

Occupation: ___________________________________(circle) Full time/ Part time /Student/ Retired

Employer / School: ____

Address: _______________________/__________________/______________/_________________
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact ____
(Name) (Relationship)

_(_____)____(_____)_____________________________
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
Is there any place you do **NOT** want me to leave a message? ____________________

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record. It is extremely important to include name on each and every e-mail sent to the clinic.

E-mail and texts are never appropriate for urgent or emergency problems.

E-mail and texts are not confidential. Employers have legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that pass through their system.

E-mail and text communications travel across the public INTERNET. It is not always possible to verify the e-mail or texts are actually received, opened or read by the addressee.

Since e-mail and texts may not be monitored while Dr. Parker is away on business or vacation, I will follow up by telephone or in person if I do not receive a response within one week.

May Dr. Parker send you educational/promotional materials such as newsletters via e-mail? Yes No

May Dr. Parker discuss your private medical information with you via e-mail? Yes No

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient ____ **Today's Date**___________

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________________ Date: __________

What are the concerns for which you are seeking care? (Primary concern first)

1. ____ Date of onset: ____________
2. ____ Date of onset: ____________
3. ____ Date of onset: ____________
4. ____ Date of onset: ____________

Who is your primary care physician? ____
(Name) (Phone if known)

For what concern did you last receive health or medical care? ________________________

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? ____

____

____

Check each that you currently use:

☐ Laxatives	☐ Pain relievers	☐ Antacids	☐ Cortisone
☐ Antibiotics	☐ Heart/Blood medication	☐ Allergy Medication	☐ Thyroid medication
☐ Sleeping pills	☐ Anti-depressants	☐ Birth Control Pills	☐ Hormones

Do you have any known contagious diseases at this time? ☐ Yes ☐ No If yes, what?____________

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer ______________	Diabetes ______________	Epilepsy ______________
Heart Disease ______________	High Blood Pressure ______________	Stroke ______________
Anemia ______________	Kidney Disease ______________	Glaucoma ______________
Allergies ______________	Asthma ______________	Mental Illness ______________
Arthritis ______________	Tuberculosis ______________	Alzheimer's Dz ______________

Name: ____ Date: ________________

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever ____ Diphtheria ____ Rheumatic fever ____ Mumps ____ Measles ____ German measles __

Have you had any immunizations? ☐ Yes ☐ No Negative Reactions? ______________________

Hospitalizations, Surgery, X-Ray and Special Studies

What hospitalizations, surgeries, x-rays, or special studies have you had?

________________________ year: _______ ___________________ year: ________

________________________ year: _______ ___________________ year: ________

________________________ year: _______ ___________________ year: ________

Allergies

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

____

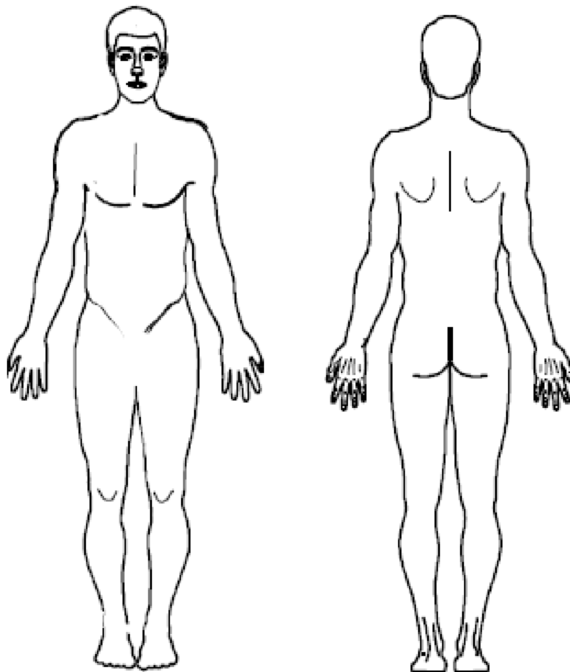
General

Weight __________ lbs. Height ___________ Weight 1 year ago ___ lbs.
Maximum (non pregnant) Weight __________ lbs. When __________________

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Main interests and hobbies? ____________
___Exercise, what kind? ______________
How often do you exercise? ____________

__Y __ N Have a religious/spiritual practice
__Y __ N Average 6-8 hrs. of sleep
__Y __ N Have a supportive relationship
__Y __ N History of abuse
__Y __ N Major traumas
__Y __ N Use recreational drugs
__Y __ N Treated for drug dependence
__Y __ N Drink coffee
__Y __ N Drink black or green tea
__Y __ N Drink cola or other sodas
__Y __ N Add salt to your food
__Y __ N Eat refined sugar
__Y __ N Enjoy your work
__Y __ N Take vacations
__Y __ N Spend time outside
__Y __ N Watch TV? How much? _______
__Y __ N Read? How often? ___________
__Y __ N Use alcoholic beverages
\# per week _____
__Y __ N Treated for alcoholism
__Y __ N Use tobacco currently
__Y __ N Used tobacco in the past
How many years? _____
How many packs per day?____

Name: ____ Date: ______________

Review of Symptoms

Check any of the following you have or have had in the past 6 months.

SKIN
___Rashes
___Eczema, Hives
___Acne, Boils
___Itching
___Fungal Infections
___Color change
___Hair Loss
___Dry skin / scalp
___Lumps
___Night Sweats
___Slow healing ulcerations
___Flushing or hot flashes

NOSE AND SINUSES
___Frequent colds
___Nose Bleeds
___Stuffiness
___Hay fever
___Sinus problems
___Loss of smell

EYES AND EARS
___Itchy eyes
___Watery eyes
___Dry eyes
___Swollen/painful eyes
___Red Eyes
___Impaired vision/Blurriness
___Floaters in vision
___Cataracts
___Color blindness
___Double Vision
___Glaucoma
___Hearing difficulty
___Ringing
___Earaches/Infection

MOUTH AND THROAT
___Sore throat
___Copious saliva
___Teeth grinding
___Sore tongue/lips
___Gum problems
___Hoarseness
___Gagging/choking
___Difficulty swallowing

HEAD / NECK
___Headache/migraine
___Faintness
___Dizziness
___Jaw Pain
___Swollen Glands
___Goiter
___Pain or stiffness
___TMJ

RESPIRATORY
___Chest congestion
___Wheezing
___Asthma
___Bronchitis/Pneumonia
___Emphysema
___Difficulty/Pain breathing
___Shortness of breath
___Tuberculosis
___Cough ___Wet or ___Dry
___Coughing blood

CARDIOVASCULAR
___Heart disease
___Angina/Chest pain
___High/Low Blood Pressure
___Murmurs
___Blood clots
___Irregular heart beat
___Palpitations/Fluttering
___Swelling in ankles

CIRCULATION
___Easy bleeding or bruising
___Anemia
___Deep leg pain
___Varicose veins
___Cold hands/feet

ENDOCRINE
___Hypothyroid
___Heat or cold intolerance
___Hypoglycemia
___Diabetes
___Excessive thirst
___Excessive hunger
___Fatigue
___Seasonal depression

IMMUNE
___Chronic Fatigue Syndrome
___Chronic infections
___Chronically swollen glands
___Slow wound healing

MUSCLES / JOINTS/ BONES
___Joint pain
___Muscle pain
___Muscle spasms / cramps
___Restless leg Syndrome
___Sciatica
___Osteoporosis

NEUROLOGIC
___Seizures
___Paralysis
___Muscle weakness
___Numbness or tingling
___Easily stressed
___Vertigo or dizziness
___Loss of balance
___Tics

DIGESTION
___Trouble swallowing
___Heartburn / Acid Reflux
___Change in thirst/appetite
___Ulcer
___Nausea/Vomiting
___Gas/Bloating
___Belching or passing gas
___Diarrhea
___Constipation
___Pain or cramps
___Mucous in stools
___Black / Bloody stool
___Hemorrhoids
___Itchy / Burning Anus
___Rectal Pain
___Liver/Gall Bladder trouble
___Jaundice (yellow skin)
Bowel Movements: How often?___
Is this a change? ____________
Stools ___Hard ___Firm
___Soft ___ Loose

Ehrin Parker, DO
Integrative Osteopathic Medicine
2243 Main Ave, Ste 1, Durango, CO 81302

Website: EhrinParker.com

Name: ____ Date: ________________

Review of Symptoms

Check any of the following you have or have had in the past 6 months.

URINARY

___Pain on urination
___Increased frequency
___Frequency at night
___Frequent infections
___Inability to hold urine
___Kidney stones
___Blood in urine

MENTAL/ EMOTIONAL

___Mood Swings
___Anxiety or nervousness
___Considered/Attempted suicide
___Depression
___Poor concentration
___Poor Memory
___Other:______________

GENERAL

___Poor Sleep / Insomnia
___Dream disturbed Sleep
___Fatigue / Low Energy
___General feel Hot
___General feel Cold
___Chills
___Fevers
___Poor Appetite
___Constant Hunger
___Cravings ___________
___Peculiar taste in mouth
___Low Libido
___Experience High Stress

MALE ONLY

___Hernias
___Testicular masses
___Testicular pain
___Prostate disease
___Sexually transmitted disease
___Discharge or sores
___Sexual dysfunction
Are you sexually active? Yes No
Sexual orientation? ___________
Birth control? Type? __________

FEMALE ONLY

___Irregular cycles
___Bleeding between cycles
___Pain during intercourse
___Clotting
___Heavy or excessive flow
___PMS
___Endometriosis
___Difficulty conceiving
___Painful menses
___Vaginal discharge? Color? ______
___Vaginal Odor
___Ovarian cysts
___Menopausal symptoms
___Abnormal PAP
___Sexually transmitted disease
___Breast pain/tenderness
___Nipple discharge
___Breast Lumps
Age at which menses began ______
Age of last menses (if menopausal)___
Length of Cycle (Day 1 to Day 1)_______
Duration of Flow _________________
Date of last period ________________
Are you sexually active? Yes No
Sexual orientation? ________________
Birth control? Type? _______________
Number of pregnancies _____________
Number of live births ______________
Number of miscarriages _____________
Number of abortions ________________
___Difficult or premature births
Do you do breast self-exams? Yes No
Date of last Pap smear ______________
Date of last mammogram ____________
_____Could be pregnant now?
Any other feminine difficulties? _______

INTEGRATED OSTEOPATHIC MEDICINE'S FINANCIAL POLICIES

1. **Unless prior arrangement is made, full payment is due at the time of service.**

   Your payment options are: cash, check, or credit/debit cards.
   We accept Visa, Master Card, Discover, or American Express.

2. **Discounts**

   We offer the following discounts. Only one discount may be applied to a bill.

   - "Medicare Discount"
   - "Multi-visit Package Discount"

3. **Missed Appointments/Late Cancellations**

   All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, **you will be charged $25 for the missed appointment.**

4. **Office Policy**

   - Emergency Services are not provided
   - We DO NOT bill medical insurance plans and are NOT contracted with any insurance companies.
   - Please do not bring unattended children to the office.

These policies are subject to change without notice.
We also post our financial policy at ehrinparker.com/financialpolicies

I have read, understood and agree to the policies described above:

Print Name:______________________________ Sign:_____________________________ Date:___________

Ehrin Parker, DO
Integrative Osteopathic Medicine
2243 Main Ave, Ste 1, Durango, CO 81302

Website: EhrinParker.com

Informed Consent for Treatment

Osteopathic Manipulative Medicine

Thank you for selecting our office for evaluation and Osteopathic treatment. We look forward to serving you.

D.O.s and Osteopathic Medicine and Manipulative Treatment

An osteopathic physician is a fully licensed physician (i.e. licensed to prescribe medicine and perform surgery) whose education combines the traditional methods of diagnosis and treatment as well as utilization Osteopathic Manipulation. The osteopathic philosophy also stresses holistic and preventive care.

Osteopathic Manipulative treatment is a form of treatment based on the concept that the structure of the human body influences the function. The goal of treatment is to improve the body's structure that in turn enables the body to function at a higher level of health. This usually reduces the amount of pain experienced by the patient as well as increases the ability of the body to fight disease (i.e. stimulates the immune system). As in most forms of medical treatment, no specific results can be guaranteed.

Treatment Program

The physician may ask questions; perform a physical examination, which could includes the musculoskeletal system in order to detect any somatic dysfunction (abnormalities such as tenderness, asymmetry, restricted range of motion and abnormal changes in the muscles, joints, bones, connective tissue, etc…). The physician's goal is to locate then reduce or resolve this somatic dysfunction. Techniques range from a very light touch to increased pressure, to an adjuster, precursor, and/ or low level laser.

Other recommendations may be given to help the dysfunction, such as diet, herbs or vitamins, exercise, life style counseling and/or stretching programs.

Treatment risks

Osteopathic manipulative treatments is considered one of the safest and most non – invasive forms of medical treatment. However, side effects may occur.

By signing below, I do hereby voluntarily consent to be treated with osteopathic manipulation. If the patient is a minor, I give my consent to have them treated. I am aware that certain adverse side effects may result from this treatment. The most serious complications that may occur are strokes, broken bone, spinal cord compression or paralysis; these are all estimated to happen one in a million manipulations.

Other adverse effects may include, but are not limited to: mild muscle aches, fatigue or tenderness, and the possible aggravation of symptoms existing prior to treatment. This vital reaction to the treatment usually resolves within few days. I understand that I may stop the treatment if it is too uncomfortable.

I understand that there may be other treatment alternatives, including traditional medication or surgery.

I understand that herb and vitamins choices may be discussed. I understand that herbs and vitamins do not treat, cure, or prevent any disease or disease process. I may choose to have Muscle testing used in conjunction with my herb choices. Muscle testing does not diagnose, prevent, or treat any disease. I will have the opportunity to discuss medication choices with Dr. Parker. If I take herbs or vitamins, it is because I choose to do so. I understand and am fully aware that there are medications I can take and have the opportunity to take.

 Customer Initials ________

I understand that a low level laser may be used as part of Osteopathic Manipulation. The low level laser has been approved by the FDA. I understand that the low level laser does not cure or prevent disease.
I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask Dr. Parker for a more detailed explanation/ I give my permission and consent to treatment.

X______________________________
Signature of patient or legal representative

X______________________________
Date

X____________________________________
Printed Name and relationship

Customer Initials ________

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Integrated Osteopathic Medicine clinic and you may obtain one at any time. This Notice goes into effect February 3, 2008.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Integrated Osteopathic Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact Integrated Osteopathic Medicine Clinic. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Integrated Osteopathic Medicine Clinic and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Integrated Osteopathic Medicine Clinic. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Integrated Osteopathic Medicine Clinic to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print)____

Patient/Guardian Signature______________________________ Date____________

Relationship to Patient (if other than self):________________________________

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.