BURNS INTEGRATIVE WELLNESS CENTER

Burns Integrative Wellness Center

34406 N. 27th Drive Suite 114
Phoenix AZ 85085

Office: 623-252-0376
Fax: 623-399-1059

General Patient Intake Form

Personal Information

Name _____ Age _____ Date of Birth _____
Height _____ Weight _____ Gender ☐ Male ☐ Female

Address _____
City _____ State _____ Zip _____

☐ Married
☐ Divorced
☐ Single
☐ Widow
Children _____

Home Phone _____
Cell Phone _____
Work Phone _____
Email Address _____

Spouse _____ Phone _____
Emergency Contact _____ Phone _____

Occupation _____ ☐ FT ☐ PT
Employer _____

Primary Care Physician _____ Phone _____
☐ Y ☐ N Is it okay if we contact them about your care?

☐ Y ☐ N Would you like to subscribe to out newsletter? [No more than 1-2 emails per month] Our newsletter includes health-related articles and healthy recipes.

☐ Y ☐ N Is it okay if we send SMS text appointment reminders to your mobile phone?

How Did You Learn About Our Office?

☐ Attorney ☐ Family ☐ Google ☐ Other _____
☐ Mailer ☐ Co-Worker ☐ Yelp ☐ Counselor / Therapist
☐ Friend ☐ Physician ☐ Facebook ☐ Instagram

If referred, by whom _____

Signature Patient | Patient Name [Printed] | Date

If needed, Signature of authroized representative | Representative Name [Printed] | Relationship to patient | Date

Authorized Facility Signature | Date

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Medical History

Current Medical Complaint_____

_____

_____

Allergies

☐ No known allergies
☐ Yes - Known allergies - list all medications, Foods, Environmental Allergies, etc…

_____

_____

_____

_____

Medications [please include prescription, herb and over-the-counter]

☐ No current medications ☐ Yes - Current medications listed

			Oral	Topical	Injection	Other	
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____
Medication_____	Dose_____	Route	☐	☐	☐	☐	_____

Surgeries

☐ No surgeries ☐ Yes - List surgeries below

Surgery	Month	Year

_____ _____ _____
Signature Patient | Patient Name [Printed] | Date

_____ _____ _____ _____
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_____ _____
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Please Check YES or NO for ALL of the Following Regarding Your Health

Y N
☐ ☐ High Blood Pressure
☐ ☐ Heart Disease / Circulatory Issues [Explain]
_____
_____
_____
☐ ☐ Stroke [date]_____
☐ ☐ Cancer / Tumor [Explain]_____
_____
_____
☐ ☐ Osteoporosis/Osteopenia, Where
_____
_____
☐ ☐ Birth Control - Type / Dose_____
_____
_____
☐ ☐ STD_____
☐ ☐ Substance Abuse_____
_____
☐ ☐ Mental Health Problems_____
_____
_____

Y N
☐ ☐ Rheumatoid Arthritis
☐ ☐ Corticosteroid Use
☐ ☐ Hives, Eczema, Rash
☐ ☐ Urinary Problems
☐ ☐ Prostate Problems
☐ ☐ Menstrual Problems
☐ ☐ Multiple Sclerosis
☐ ☐ Dizziness / Fainting
☐ ☐ Epilepsy / Seizures
☐ ☐ Liver disease
☐ ☐ Kidney disease
☐ ☐ ADD / ADHD
☐ ☐ Unusual Spots / Moles
☐ ☐ History of Head Injury
☐ ☐ Sleep Disorders [Sleep apnea, insomnia]
☐ ☐ Abnormal weight ☐ Loss ☐ Gain
☐ ☐ Thyroid ☐ Hypo ☐ Hyper
☐ ☐ Asthma / Lung disease / Difficulty breathing
☐ ☐ Temperature/Pressure Sensitivity
☐ ☐ Bruise easily / Bleeding problems
☐ ☐ Intestinal disorders [IBS, Ulcers]

Y N
☐ ☐ Diabetes
☐ ☐ Stress
☐ ☐ Pain at night
☐ ☐ Headaches
☐ ☐ HIV / AIDS
☐ ☐ Wear Contacts
☐ ☐ Night sweats
☐ ☐ Recent fever
☐ ☐ Hepatitis

☐ ☐ Broken Bones / Fractures_____
☐ ☐ Surgeries / Hospitalizations_____
_____
_____
☐ ☐ Other health related issues_____
_____
_____

Last physical date_____

Female Patients Only

Y N
☐ ☐ Are you pregnant? If *yes*, # weeks _____
☐ ☐ Are your currently breast feeding?

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Physical / Social History

Exercise

☐ None
☐ Moderate
☐ Heavy
Days/week_____

Work Activity

Y N
☐ ☐ Sitting
☐ ☐ Standing / Bending
☐ ☐ Light Labor
☐ ☐ Heavy Labor

Drug and Alcohol History

Y N
☐ ☐ Tobacco — Cigarettes / day _____
☐ ☐ Alcohol — Drinks / week _____
☐ ☐ Caffeine — Drinks / day _____
☐ ☐ Cocaine / Meth
☐ ☐ Opiates/Prescription, heroin or methodone
☐ ☐ Hallucinogens [Ecstasy, LSD, Mushrooms]
☐ ☐ Other_____

Y N NA
☐ ☐ ☐ Would you like help quitting?

General

Y N
☐ ☐ High Stress_____
_____

Family History

Mother's side

Y N
☐ ☐ Cancer [Type]_____
☐ ☐ Heart Disease - Age_____
☐ ☐ Stroke - Age_____
☐ ☐ High Blood Pressure
☐ ☐ Diabetes
☐ ☐ Rheumatoid Arthritis
☐ ☐ Other_____
☐ ☐ _____

Father's side

Y N
☐ ☐ Cancer [Type]_____
☐ ☐ Heart Disease - Age_____
☐ ☐ Stroke - Age_____
☐ ☐ High Blood Pressure
☐ ☐ Diabetes
☐ ☐ Rheumatoid Arthritis
☐ ☐ Other_____
☐ ☐ _____

Cancellation Policy

To better serve our patients, we require 24-hour notice if an appointment is to be canceled or rescheduled. This will ensure maximum availability to all patients who need to see us.

If you do not provide us 24 hours advance notice of cancellation you will be responsible for the entire payment of the office visit.

Prescription Refill Policy

Burns Integrative Wellness Centerwill call in prescription refills within 48 hours of receiving the request on business days, Monday through Friday, except for holiday schedules. Please plan your refills accordingly.

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Information Provided

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.

Consent for Use and Disclosure of Health Information

We here at Burns Integrative Wellness Centerare very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information

1. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news.

Burns Integrative Wellness Center, it's staff or employees, may from time to time schedule appointments for other healthcare providers, when requested. These providers are not partners or contractors of Burns Integrative Wellness Center. All health and patient information disclosed to Burns Integrative Wellness Center, it's employees or staff, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA, are complied with.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

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If needed, Signature of authroized representative	Representative Name [Printed]	Relationship to patient	Date
Authorized Facility Signature			Date