ETHOS MEDICAL GROUP

PATIENT INTAKE FORMS

How did you hear about Ethos Medical? _____ Date: _____ / _____ / _____

First Name: _____ Last Name: _____

DOB: _____ / _____ / _____ Sex: ☐Male ☐Female Preferred Method of Contact: ☐Phone ☐Text ☐E-Mail

Address *(Street, Apt/Unit)*: _____ City: _____

State: _____ Zip Code: _____Preferred Method of Contact: ☐Phone ☐Text ☐E-Mail

Cell Phone: _____ E-Mail: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed # of Children: _____

Emergency Contact Name: _____ Relationship to Patient: _____

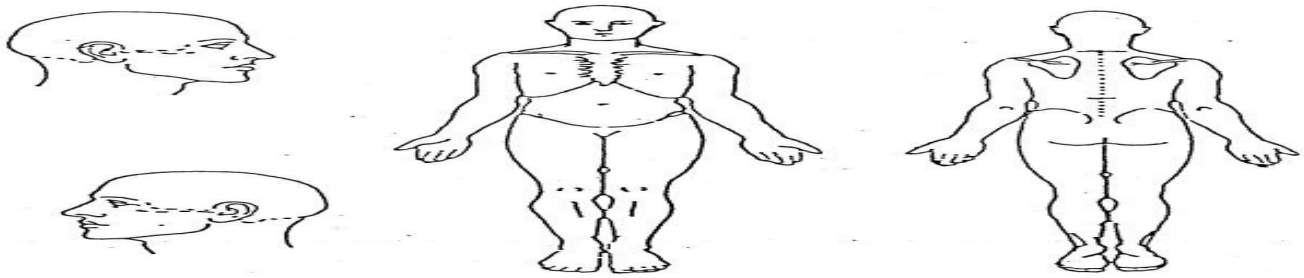
Emergency Contact Info: Cell Phone: _____ E-Mail: _____

List the Symptoms, Complaints, and Health Conditions you are wanting help with *(in order of importance to you)*:

_____ When did the issue begin? _____

_____ When did the issue begin? _____

Please mark (**X**) on the picture below where you have any discomfort, pain, or other symptoms:



What do you believe caused your problem? _____

Any Imaging for these complaints? ☐U/S ☐X-Ray ☐CT ☐MRI ☐Other Date(s): _____

Injury/Accident: ☐Motor Vehicle Accident ☐Work Injury If Yes, Date: ____ / ____ / _____

Have you consulted another Provider or received care? ☐No ☐Yes If Yes, Date: ____ / ____ / _____

Please mark below what you have tried in the past that has NOT fixed your complaints:

☐Medications ☐Acupuncture ☐Physical Therapy

☐Injections ☐Homeopathy/Herbal ☐Chiropractic

☐Surgery ☐Personal Training ☐Massage Therapy

☐Supplements ☐Exercise ☐Other: _____

☐Heat/Ice

Please mark any of the following that may suffer or are more difficult/less enjoyable because of your complaints:

☐Quality Family Time ☐Productivity/Focus/Work ☐Travel/Vacation/Leisure

☐Sleep Quality ☐Sitting/Driving ☐Exercise/Sports

☐Housework ☐Focus/Mood ☐Walking

☐Self-Care/Bathing ☐Hobbies ☐Standing

Do you have a Primary Care Physician? ☐No ☐Yes Physician's Name: _____

Clinic Name: _____ City/Location: _____

Phone _____ Last Physical Date: ____ / ____ / _____ Last Blood Work Date: ____ / ____ / _____

Your Most Important Goal for Today's Visit:_____

FEMALE PATIENTS: *(Patient Initials*: _____) Are you pregnant? ☐No ☐Yes Due Date: _____

Birth Control: ☐No ☐Yes Start Date:_____ HRT/Testosterone: ☐No ☐Yes Start Date:_____

List ALL Medications you take on a regular basis *(prescribed, OTC, supplements, herbs, etc)*:

_____

_____

Smoker: ☐No ☐Yes Past/Quit Date: ____ / ____ / _____ Special Diet: ☐No ☐Yes, Type: _____

Steroids: ☐No ☐Yes *If Yes,* ☐Orally ☐Injections ☐ESI/Epidural Date(s): _____

Cancer: ☐No ☐Yes *If Yes,* Location: _____ Blood Disorder: ☐DVT ☐Clotting ☐Easily Bruised

Rate 0-10 Scale: Exercise_____ Energy_____ Sleep Quality_____ # Hours_____ Position: ☐Side ☐Stomach ☐Back

Any Broken/Dislocated Joints or Bones? ☐No ☐Yes *If Yes,* List the Areas and Dates below:

_____

_____

Any Surgeries (including cosmetic)? ☐No ☐Yes *If Yes,* List the Procedures and Dates Below:

_____

_____

Please mark (X) on the corresponding boxes for each symptom or condition you have experienced:

(Past = if you have experienced in your lifetime; Current = experienced in the past 6 months)

	Past	Current		Past	Current		Past	Current
NEURO/MUSCULOSKELETAL			Arthritis			**ENDOCRINE**		
Headaches / Migraines			*Spine*			Type 1 Diabetes		
Facial Pain, Weakness, Numbness			*Other*			Type 2 Diabetes		
Jaw: Clenching / Pain / TMJD			Osteoporosis/ Osteopenia			Decreased Libido		
Tinnitus / Ringing in Ears			Rheumatoid Arthritis			Erectile Dysfunction		
Dizziness / Vertigo / Balance			Decreased Flexibility			Excess Hair Growth		
Fall Frequently / Clumsy			Carpal Tunnel Syndrome			Hypothyroidism		
Blurred Vision / Blindness			Postural Changes			Low Testosterone		
Tremors / Parkinson's			Scoliosis			High Blood Pressure		
Dementia			Neck Pain or Stiffness			Overweight / Underweight		
Memory Loss			Mid Back Pain			Postmenopausal		
ADD / ADHD / Focus Problems			Low Back Pain			Thinning / Loss of Hair		
Anxiety / PTSD			Sciatica			**GASTROINTESTINAL**		
Depression			Disc Degeneration			Excessive Thirst		
Sleep Disturbances / Insomnia			Shoulder Pain / Injury			Constipation		
Sleep Apnea			Elbow Pain / Injury			Gas/Bloating		
Fatigue			Wrist & Hand Pain / Injury			GERD / Heartburn / Reflux		
Fibromyalgia / CFS			Hip Pain / Injury			IBS / Chron's		
Weakness In Extremities			Knee Pain / Injury			Frequent Nausea/Vomiting		
Area:			Foot & Ankle Pain / Injury			Autoimmune: Lupus or GBS		
Numbness / Tingling Extremities			Spine Surgery			**SKIN**		
Neuropathy			Pain Pump			Cellulitis		
Edema / Swelling			Rhizotomy			Psoriasis/Eczema		
Frequent/Recurring Illness(es)			Cosmetic Surgery:			Dermatitis		
Allergies (Food)			*Area:*			Excessive Sweating		
Allergies (Environmental)			Implants: *Breast or Other*			Itchiness / Rashes		
Sensitive To Sound			Pacemaker			Heal Slowly		
Sensitive To Cold/ Renaud's						Acne Prone		
Sensitive To Light						Bruise Easily		

PRIVACY AUTHORIZATION HIPAA AND PHI

Our goal is to make your experience with us exceptional. Your signature below verifies that you have been given the option to review and understand our notice of HIPAA/PHI patient privacy practices. You agree that we may contact you via email, phone,or mail regarding your care and to keep you up to date on events taking place within the office. We will not share your information. We use audio, video, and photos at functions, during training and in office for research studies, testimonials, and/or social media.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I authorize Ethos Medical to discuss my medical condition with the following individuals: *(name, relationship, phone number)*

_____ _____

_____ _____

_____ _____

ASSIGNMENT OF INSURANCE BENEFITS

Your Insurance Company: _____We will verify your insurance before your exam, we will discuss anyinsurance coverage, along with any expected contributions towards our Medical Providers recommendations for the Testing and Exams required to get a diagnosis, and any prescribed treatment. As a courtesy, we will file directly to your insurance company foryour exam and any recommended treatment. All fees for today's exam, scans, and any x-rays will be due in full today. All fees will be discussed with you *prior to any services being performed* today.

The undersigned patient and or responsible party, in addition to continuing personal responsibility and consideration of treatments rendered, assigns to Ethos Medical the following rights:

RELEASE OF INFORMATION

You are authorized to release information concerning my condition and treatment to my insurance company, or insurance adjuster,for purposes of processing/appealing my claim for benefits and payment of services.

ALL PAYMENTS FOR SERVICES WILL BE MADE PAYBALE TO: ETHO REGENERATIVE MEDICAL GROUP, PLLC.

I hereby grant Ethos Regenerative Medical Group, PLLC the power to endorse my name upon any checks, drafts, or other negotiableinstrument representing payment from any insurance group, company representing payment for treatment, consultations and all health care rendered.

Printed Name *Signature of the Patient, Parent or Guardian* *Date*