center for vital health

PATIENT INFORMATION-**Please print**

Name____Goes by_________________
First MI Last

Mailing Address____
Street Address /PO Box City State Zip

Social Security #______________________Birth Date_______________ Spouse/Partner name__________________

Partner status: Single Married Divorced Widow/er Separated Patient's sexual identity_________________

Employer____Phone # (_____) _________________________

Emergency Contact____Phone # (_____) _________________________

How did you hear about our office?____

INSURANCE INFORMATION We do not file insurance. We will give you the superbill to submit to your insurance.

Do you have **Medicare**? Y N Do you have **Medicaid**? Y N Is this related to a **Motor Vehicle Accident** Y N

RELEASE OF INFORMATION

Daytime Phone # (____)_____________________Ok to leave a voice message? Yes No

Email Address____Ok to send email? Yes No

Is there anyone else that we can talk to about your medical care or who may call on your behalf?

Name____Telephone #_______________________________

PLEASE INITIAL:

_________I understand there is a $50 fee for appointments not canceled 24 hours in advance.

_________I understand there is a 70% fee for Prolo/PRP appointments not canceled 48 hours in advance.

_________I understand that there is a $50 return check fee

_________I understand that Dr. Harrow will not accept assignment from my insurance company.

_________I understand that Dr. Harrow is only on-call for patients who have had a procedure in the office. All other patients need to call during business hours or contact urgent care.

_________I understand that neither Dr. Harrow nor any staff member will communicate with my insurance company about claims I submit.

All of the above statements are true and correct. I understand that I am responsible for payment on my account.

X____
Signature Date

center for vital health, inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective Date of this Notice: 04/14/2003

With my consent, Center for Vital Health, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Center for Vital Health, Inc.'s *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. Center for Vital Health, Inc. reserves the right to revise the *Notice of Privacy Practices* anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Center for Vital Health, Inc. at Center for Vital Health, Inc., 1485 Garden of the Gods Road, Suite 172, Colorado Springs, CO 80907.

With my consent, Center for Vital Health, Inc. may mail to my home, or other designated location, any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements; as long as they are marked 'Personal and Confidential.'

I have the right to request that Center for Vital Health, Inc. restrict how the practice uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Center for Vital Health, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, Center for Vital Health, Inc. may decline to provide treatment to me.

_________________________ Date

______________________________________ Patient's Signature (parent/legal guardian if under 18)

______________________________________ Patient's Printed Name

Medical Symptoms Questionnaire (MSQ)

Patient Name________________________________ Date______________

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
- **0** – ***Never or almost never*** have the symptom
- **1** – ***Occasionally*** have it, effect is ***not severe***
- **2** – ***Occasionally*** have it, effect is ***severe***
- **3** – ***Frequently*** have it, effect is ***not severe***
- **4** – ***Frequently*** have it, effect is ***severe***

HEAD

________ Headaches
________ Faintness
________ Dizziness
________ Insomnia

Total ________

EYES

________ Watery or itchy eyes
________ Swollen, reddened or sticky eyelids
________ Bags or dark circles under eyes
________ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total ________

EARS

________ Itchy ears
________ Earaches, ear infections
________ Drainage from ear
________ Ringing in ears, hearing loss

Total ________

NOSE

________ Stuffy nose
________ Sinus problems
________ Hay fever
________ Sneezing attacks
________ Excessive mucus formation

Total ________

MOUTH/THROAT

________ Chronic coughing
________ Gagging, frequent need to clear throat
________ Sore throat, hoarseness, loss of voice
________ Swollen or discolored tongue, gums, lips
________ Canker sores

Total ________

SKIN

________ Acne
________ Hives, rashes, dry skin
________ Hair loss
________ Flushing, hot flashes
________ Excessive sweating

Total ________

HEART

________ Irregular or skipped heartbeat
________ Rapid or pounding heartbeat
________ Chest pain

Total ________

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

Now add up your "Yes" answers: _______ This is your ACE Score

center for vital health, inc.

DIRECTIONS TO OUR OFFICE

center for vital health inc.
1485 W Garden of the Gods Road
Suite 172
Colorado Springs, CO 80907
719.531.6778

Westbound:

From I-25 : Exit West on Garden of the Gods Road, make a U-turn at the second left after Centennial (you will then be heading East). Turn right right into our parking lot. Our office is located on the West side of the brown stucco building with black glass. You will see Farmers Insurance Company in the front of the complex. Across the street will be Trinity Brewing, Sherwin Williams and Kum & Go

Eastbound:
Heading East on Garden of the Gods Rd, we are the fifth right off of Garden of the Gods, a block past the county building.

Landmarks :
We are located across the street from a complex with Sherwin Williams Paint Store and Trinity Brewing Company.