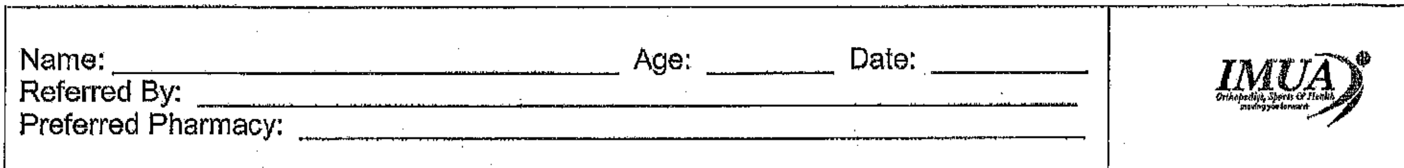
PHYSICAL EXAM FORM - NYG RM#: ____ INS: ______________ N: __


Name: ______________________ Age: ________ Date: __________
Referred By: ______________________
Preferred Pharmacy: ______________________

What is the reason for your visit today? ______________________
Location of Pain/Problem: ______________________
When did the pain/problem start (date)? ______________________
How did the symptoms/condition start? ______________________

****

Systems Review – Please indicate "Yes" or No." If answer is "Yes," please describe the problem.

	YES	NO	TYPE
1. Recent cold or flu?			
2. Recent skin problems?			
3. Recent eye/ear problem?			
4. Recent nerve problem?			
5. Recent depression/anxiety?			
6. Recent respiratory problem?			
7. Recent heart problem?			
8. Recent intestinal problem?			
9. Recent urinary problem?			
10. Recent bleeding problems?			

ALLERGIES (please list what you are allergic to and the type of reaction): ______________________

CURRENT MEDICATIONS

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

SUPPLEMENTS (e.g. Vitamins, St. John's Wort, Ginseng, Creatine): ______________________

PAST MEDICAL HISTORY – Please indicate "Yes" or "No"

CONDITION	YES	NO
Coronary Artery Disease		
High Blood Pressure		
Heart Attack		
Murmur		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Hyperlipidemia		
Stroke		
Seizure		
Kidney Failure		
Diabetes		
Thyroid Disease		

CONDITION	YES	NO
Gout		
Cancer		
If yes, Type:		
Asthma		
Tuberculosis		
Emphysema		
Hepatitis		
Ulcer		
GI Bleed		
Anemia		
Bleeding Disorder		
Deep Vein Thrombosis		

PAST SURGICAL HISTORY

Type of Surgery	Date of Surgery	Surgeon

PAST FAMILY HISTORY – Please indicate "Yes" or "No" if it pertains to an immediate family member only (e.g. parent, sibling, or grandparent)

CONDITION	YES	NO	RELATIONSHIP
Coronary Artery Disease			
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Thyroid Disease			
Cancer			
Hepatitis			
Anemia			
Bleeding Disorder			

SOCIAL HISTORY

Tobacco Use: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker
If Yes, Type: ☐ Cigarette ☐ Pipe ☐ Cigar ☐Other ____________
# of Packs per day: __________ # of years smoking: __________

Alcohol Use: ☐ Yes ☐ No
If Yes: How many days per week do you drink alcohol? ____
On a typical day when you drink, how many drinks do you have? ____
What is the maximum number of drinks you had on any given day in the past month? ____

Caffeine Use: ☐ Yes ☐ No
If Yes: Frequency: ____________________ Quantity per day: ____________________

Recreational Drug Use: ☐ Yes ☐ No
If Yes: Type of Drug(s): ____
Frequency: ____________________ Quantity per day: ____________________

Sports/Exercise: Type: ________________ # Days per Week _____ Duration per Session: _________

Over the past 2 weeks, have you felt down, depressed, or hopeless? ☐ Yes ☐ No
Over the past 2 weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

Do you have any sexual activity concerns? ☐ Yes ☐ No
History of multiple partners? ☐ Yes ☐ No
History of sexually transmitted diseases? ☐ Yes ☐ No

OB/GYN HISTORY (for FEMALES only)

Age of onset of menstruation __________ How many days do your cycles last? __________
When was your last visit with a gynecologist? __________ Date of your last pap smear? __________
Date of your last mammogram? __________
Have you ever had an abnormal mammogram? ☐ Yes ☐ No
Pregnancy History: # of Vaginal Births ___ # of Caesarian Sections ___
# of Stillbirths/Miscarriages ___ # of Pregnancy Terminations ___

PREVENTATIVE HEALTH SCREENINGS

Please provide the dates of your last screening for the following:

Exam	Date	Immunization	Date
Colonoscopy		Tetanus Vaccine (specific Td or Tdap)	
Test of stool for blood (Stool Guaiac)		Flu Vaccine	
Rectal prostate exam (males)		Pneumonia Vaccine	
Prostate Specific Antigen (PSA) (males)		Zoster (Shingles) Vaccine	
Bone Density (Dexa)		Hepatitis A (Vaccine)	
Eye Exam		Hepatitis B Vaccine	
Cardiovascular Stress Test		MMR Vaccine	
Other		Gardasil (HPV) Vaccine	
		Other	

PERSONAL/PROFESSIONAL DEVELOPMENT

Current Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time Occupation: ____________________
☐ Retired ☐ Disabled ☐ Care-Taking ☐ Unemployed

NUTRITION HISTORY

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Describe: ____________________

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat
☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism
☐ Specific Program for Weight Loss/Maintenance Type: ____________________ ☐ Other: ____________

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you avoid particular foods? ☐ Yes ☐ No

If yes, types and reason: ____________________

If you could only eat a few foods a week, what would they be? ____________________

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? ____________

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking? ____________

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance of convenience items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods

☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship with food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: ____________________

____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total _______

EARS

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

Total _______

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

Total _______

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

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 _______

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total _______

HEART

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

Total _______

JOINTS/MUSCLES

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

Total _______

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total _______

MIND

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

Total _______

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total _______

NOSE

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

Total _______

SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total _______

WEIGHT

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

Total _______

OTHER

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

Total _______

GRAND TOTAL _______

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

- Optimal is less than 10
- Mild Toxicity: 10-50
- Moderate Toxicity: 50-100
- Severe Toxicity: over 100

REGISTRATION FORM

❒ Elizabeth M. Ignacio, MD
❒ Nicole Y. Gesik, DO

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth
Address	City	State	Zip
Phone (Please ✓ Primary #)	❒ Home Phone	❒ Work Phone	❒ Cell Phone

Gender ❒ M ❒ F	SSN	Occupation	Employer

Marital Status	Work Status	School Status	Ethnicity	Race
❒ Single	❒ Full-Time	❒ Full-Time	❒ Hispanic/Latino	❒ American Indian or Alaska Native
❒ Married	❒ Part-Time	❒ Part-Time	❒ NON-Hispanic	❒ Asian
❒ Divorced	❒ N/A	❒ N/A	❒ Unknown/Refused	❒ Black/African American
❒ Widowed		School:	**Preferred Language**	❒ Native Hawaiian/Pacific Islander
❒ Other			❒ English	❒ White
			❒ Other	❒ Other

Please tell us how you heard about us:
❒ Doctor ❒ Friend/Relative ❒ Internet ❒ Television ❒ Other

Name of Referring Doctor or Friend/Relative	Primary Care Provider

INSURANCE INFORMATION

❒ Private Insurance ❒ Workers' Compensation ❒ No-Fault ❒ Third Party Liability

Condition we are treating you for today:	Date of Injury/Onset:	
If WC of NF Injury, Adjuster's Name:	Phone:	Fax:

Primary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:
Policy or Claim #:	Pt's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other	

Secondary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:
Policy or Claim #:	Pt's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other	

Tertiary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:
Policy or Claim #:	Pt's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other	

RESPONSIBLE PARTY INFORMATION (Complete ONLY if different from patient)

Last Name	First Name	MI	Date of Birth
Address	City	State	Zip
Phone (Please ✓ Primary #)	❒ Home Phone	❒ Work Phone	❒ Cell Phone

Gender ❒ M ❒ F	SSN	Occupation	Employer

If patient is a minor, person(s) who may authorize treatment: ______________________________

Relationship to patient: ______________________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________________

Phone (Please ✓ Primary #)	☐ Home Phone	☐ Work Phone	☐ Cell Phone

RELEASE OF INFORMATION

I authorize the release of confidential medical information to the following persons:

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

APPOINTMENT REMINDERS

I'd like receive appointment reminders by: (you may select both options)	☐ Text Phone #: ______________________ ☐ E-Mail Email Address: ______________________

I would like to receive the IMUA Orthopedics, Sports & Health email newsletter: ☐ Yes ☐ No, thank you

☐ To email address listed above ☐ Alternate email: ______________________

ACKNOWLEDGEMENTS & CONSENTS

I verify that the information provided above is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to ***IMUA Orthopedics, Sports & Health*** *for any services furnished to me.*

I authorize IMUA Orthopedics, Sports & Health, LLC to disclose/request my health information, including copies of records as necessry, to/from:

1. *Any health insurance plan, company, or billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagositc facilities, labs, radiology/imaging, outpatient facilities and hospitals, and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for IMUA Orthopedics, Sports & Health to evaluate clinical performance.*
4. *Any workers' compensation, no-fault, or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by IMUA Orthopedics, Sports & Health, LLC as detailed above.

Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I hereby give my consent to IMUA Orthopedics, Sports & Health to use or disclose, for purposes of carrying out treatment, payment, or healthcare operations, all protected health information contained in the health record of ______________________ (print patient's name). I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to disclose my health information. Written revocation of consent must be sent to this facility.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was made aware of IMUA Orthopedics, Sports & Health's Privacy Policy and a copy was available for my review.

Acknowledgement of Receipt of Office and Financial Policies:

I acknowledge that I have reviewed and received a copy of the Office and Financial Policies of IMUA Orthopedics, Sports, & Health, LLC

My signature below indicates my full understanding and consent to the above-described policies

______________________ ______________________

Signature Date

______________________ ______________________

Print Name Relationship to Patient

Welcome to IMUA Orthopedics, Sports & Health! We are glad that you have chosen us to take care of your health care needs, and we look forward to partnering with you to realize your health care goals. In order to keep you informed of our Office and Financial Policies, we ask that you read and sign our acknowledgement prior to any treatment. Please speak with us if you have any questions.

OFFICE POLICIES

APPOINTMENTS – The office hours for each physician will vary, but every effort will be made to accommodate the date and time desired. Office visits are by appointment only. While every effort will be made to keep your wait time to a minimum, emergencies do occur and will be given priority. We will attempt to contact you as soon as possible to provide the option of rescheduling your appointment

CANCELLED APPOINTMENTS / NO SHOWS - If it is necessary to cancel your appointment, we kindly ask that you give us at least 24 hours notice so that we may accommodate other patients in need of our services. Please note that a $30.00 Cancellation/No Show fee may be billed to you (which is not payable by your insurance) for any missed appointments if proper notification has not been received by our office. Patients arriving more than 15 minutes after their scheduled appointment will be considered a "No Show." Repeated "No Shows" may result in a temporary suspension of services.

AFTER HOURS EMERGENCIES – If you are having a medical emergency, please call 911 immediately and go to your nearest emergency room. Our physicians can also be reached after hours through the Physicians Exchange at 524-2575.

PRESCRIPTION REFILLS – Please call our office during normal business hours to obtain medication refills. This will allow your physician to consult your medical record and make the best decision regarding your care. Prescriptions will be called in within 48 hours of request. Refills will not be handled after hours, and will be only considered under emergency circumstances.

MEDICAL FORMS COMPLETION - A $10.00 - $25.00 fee will be charged for completion of insurance forms such as TDI, Life Insurance, or Flexible Spending forms (the charge is based upon the number of pages and complexity of the information requested). Payment is required at the time the forms are picked up.

REQUEST FOR COPIES OF MEDICAL RECORDS - If you are requesting a copy of your medical records for yourself or a third party, we require a signed authorization by the patient or their Legal Representative. This form may be faxed in to (808) 521-8127. Please allow ten (10) days' notice. There may be a fee charged for this, and payment in full is required before the records can be released.

FINANCIAL POLICIES

IMUA Orthopedics, Sports & Health participates with most insurance plans. We will gladly file claims on your behalf, however, payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party. You will be required to complete an Injury/Illness form stating that your injury is NOT the result of a third party's liability.

HMO / MANAGED CARE PLAN REFERRALS - Some insurance plans require that you obtain a referral from your primary care provider in order for your visit to be covered. Failure to obtain the necessary referrals may lead to your visit being denied, and as a result, your having to be responsible for the entire balance. If you arrive for your appointment without a referral, we reserve the right to reschedule your appointment.

WORKERS' COMPENSATION / AUTOMOBILE ACCIDENT / THIRD PARTY LIABILITY – If your injury is a result of a work-related injury, automobile accident, or due to another party's negligence, we must have approval from your adjuster prior to your visit. Failure to properly report the injury to your employer/insurance carrier may result in your claim being denied and the balance being your responsibility.

PAYMENT AT TIME OF SERVICE - We ask that you remit payment for any applicable co-payments, deductibles, or co-insurance amounts at the time of service. Once your insurance carrier has processed your claim, any outstanding balance not collected at the time of service will be billed to you.

If you do not have any insurance coverage, we do not participate with your insurance carrier, or if there is a question of whether or not your insurance carrier will cover your visit, we require payment in full at the time of service. In the event that your insurance carrier does make payment, you will be refunded your payment less any balance due.

If you do have an outstanding balance due, we would appreciate your prompt payment in full. In the event that you are unable to make payment in full, please call our business office at (808) 521-8170 and we will be happy to arrange a payment plan for you.

DELINQUENT ACCOUNTS - If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn your balance over to a collection agency. In addition to the balance due, you will also be responsible for any legal or collection agency fees due.

RETURNED CHECKS – A $20.00 fee will be assessed for each check returned for insufficient funds.

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

What is Functional Medicine?

Functional Medicine is an evolution in the practice of medicine that better addresses the healthcare needs of the 21st century.

By shifting the traditional disease-centered focus of medical practice to a more patient-centered approach, functional medicine addresses the whole person, not just an isolated set of symptoms. Functional Medicine practitioners spend time with their patients, listening to their histories and looking at the interactions among genetic, environmental, and lifestyle factors that can influence long-term health and complex, chronic disease. In this way, Functional Medicine supports the unique expression of health and vitality for each individual.

WHY DO WE NEED FUNCTIONAL MEDICINE?

- **Our society is experiencing a sharp increase in the number of people who suffer from complex, chronic diseases,** such as diabetes, heart disease, cancer, mental illness, and autoimmune disorders like rheumatoid arthritis.
- **The system of medicine practiced by most physicians is oriented toward acute care,** the diagnosis and treatment of trauma or illness that is of short duration and in need of urgent care, such as appendicitis or a broken leg.
- **Unfortunately, the acute-care approach to medicine lacks the proper methodology and tools for preventing and treating complex, chronic disease.**
- **There's a huge gap between research and the way doctors practice.** The gap between emerging research in basic sciences and integration into medical practice is enormous—as long as 50 years—particularly in the area of complex, chronic illness.
- **Most physicians are not adequately trained to assess the underlying causes** of complex, chronic disease and to apply strategies such as nutrition, diet, and exercise to both treat and prevent these illnesses in their patients.

HOW IS FUNCTIONAL MEDICINE DIFFERENT?

Functional Medicine involves understanding the ***origins, prevention, and treatment*** of complex, chronic disease. Hallmarks of a Functional Medicine approach include:

- **Patient-centered care.** The focus of functional medicine is on patient-centered care, promoting health as a positive vitality, beyond just the absence of disease.
- **An integrative, science-based healthcare approach.** Functional Medicine practitioners look "upstream" to consider the complex web of interactions in the patient's history, physiology, and lifestyle that can lead to illness. The unique genetic makeup of each patient is considered, along with both internal (mind, body and spirit) and external (physical and social environment) factors that affect total functioning.
- **Integrating best medical practices.** Functional Medicine integrates traditional Western medical practices with what are sometimes considered "alternative" or "integrative" medicine, creating a focus on prevention through nutrition, diet, and exercise; use of the latest laboratory testing and other diagnostic techniques; and prescribed combinations of drugs and/or botanical medicines, supplements, therapeutic diets, detoxification programs, or stress-management techniques.

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