170 US Route 1
Falmouth, Maine 04105
207.482.0188 F:888.642.8601

www.Integr8Health.com

964 Western Ave.
Manchester, Maine 04351
207.512.8633 F:888.688.0407

NEW PATIENT HEALTH HISTORY

Welcome To Integr8 Health. Thank You For Choosing Us For Your Health Care.

Name: _____ Date of Birth: _____ Age: _____

PLEASE STATE YOUR CURRENT HEALTH CONCERN(S):

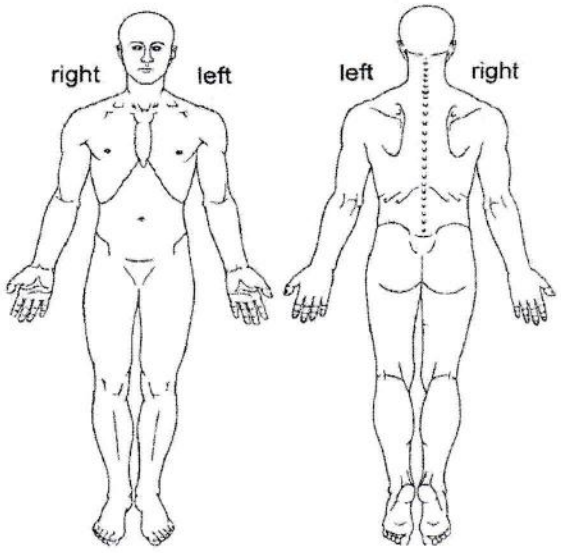
_____

_____

PAIN PATTERNS MAP →→→

On the figures provided to the right, please "illustrate" your areas of pain and/or numbness using the following key:

Moderate Pain = O O O O O
Severe Pain = X X X X X
Numbness = N N N N N
or tingling.



FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

What are the symptoms?

_____

What makes it better, and what makes it worse?

_____

_____

_____

Does it interfere with your ability to function or sleep? Please describe.

_____

_____

Name:_____ Date of Birth_____

When and how did this condition start?

_____

_____

What types of examinations have you had (doctors seen, tests performed, etc.)?

_____

_____

What treatments have you tried and how well have they worked?

_____

_____

PLEASE LIST YOUR CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage):

_____

_____

_____

_____

PLEASE LIST ANY ALLERGIES (medications, food or environmental & your reactions):

_____

_____

DO YOU CURRENTLY HAVE A PRIMARY CARE PROVIDER? YES NO

Name & Town / Practice_____

What other medical providers are involved in your care?

_____

_____

CANNABIS HISTORY:

Are you currently using cannabis? YES NO (If no, please skip to next section).

How? Please circle: pipe, joint, vaporizer, tincture, edible, juicing, topical, concentrates, other:_____

How much cannabis do you use? (eg. 2 puffs twice daily, 1/4 ounce per week, 40mg daily, etc.)

_____

Which strains work well, which don't?

_____

How does cannabis help you?

_____

_____

Have you had any negative effects from cannabis? YES NO If yes, please describe:_____

_____

Name:_____ Date of Birth_____

MEDICAL HISTORY:

Please list any other major health problems, hospitalizations, and surgeries that you have had and when:

_____

_____

_____

Please list any traumas you have experienced (accidents, falls, head injuries, abuse as a child, loss of loved ones, fires, abusive relationships, sexual assault, military combat, etc.):

_____

_____

_____

Have you been diagnosed with any of the following illnesses? (please circle)

Fibromyalgia, Chronic Fatigue Syndrome, POTS, Rheumatoid arthritis, Lupus, Multiple Sclerosis, ALS, Bell's Palsy, Costochondritis, Transverse Myelitis, Idiopathic Neuropathy, Dementia.

Have you ever been bitten by a black legged (deer) tick? **YES NO**

If yes, did you get a circular rash in the area of the bite? **YES NO**

Have you ever experienced a strong flu like illness in the summer or fall from which you never fully recovered? **YES NO**

Do you have any of the following symptoms? (please circle)

Joint pain or swelling; Severe fatigue that is worse after activity; Numbness; Tingling; Radiating pain; Muscle or tendon aches; Pain in your ribs, chest, or between the shoulder blades; Swollen glands; Unexplained fevers, sweats, or chills; Unexplained lapses in memory, attention, concentration, or the ability to process numbers; Unprovoked mood swings; Feel like you've aged prematurely.

Do the above problems seem to come and go without a clear cause? **YES NO**

Have you noticed a pattern in the occurrence of these symptoms (e.g. monthly)? **YES NO**

Do the symptoms move around from one area of the body to another or switch sides? **YES NO**

Other Symptoms (Please circle any that you've experienced <u>in the last 2 weeks</u>):

GENERAL: Persistent Fatigue; Weakness; Fever/chills; Dizzy; Fainting; Weight loss/gain

HEAD: Headaches; Eye pain; Trouble seeing; Trouble hearing; Ringing in ears; Ear pain; Stuffed nose; Tooth pain; Sore throat; Swollen glands.

BREATHING: Cough; Excess phlegm; Bloody phlegm; Shortness of breath; Wheezing.

HEART & CIRCULATION: Chest pains; Swollen ankles; Trouble breathing when laying down; Trouble walking up stairs; Legs cramp after walking; Heart races or skips beats.

DIGESTIVE: Heartburn or reflux; Belly pain; Poor appetite; Nausea; Vomiting; Constipation; Diarrhea; Blood in vomit or stools; Black or tarry stools; Excess belching or passing gas; Rectal pain.

URINARY: Pain or burning with urination; Frequent urination; Blood in urine; Decreased urine stream; Leaking urine.

Name:_____ Date of Birth_____

MUSCULOSKELETAL: Back pain; Painful muscles; Painful joints; Swollen joints; Morning stiffness; Muscle cramps.
NEUROLOGICAL: Radiating pain; Tingling; Numbness; Weakness; Blackouts; Tremors; Seizures; Trouble with balance or coordination; Memory changes.
MENTAL HEALTH: Persistent sadness; Worry; Anxiety; Guilt; Fear; Paranoia; Over-energized; Trouble paying attention; Panic attacks; Irritability; Flashbacks; Under-eating; Overeating; Thinking about harming myself / another.
OTHER: Can't tolerate heat / cold; Excessive sweating; Nipple leaking; Change in appetite / thirst; Rash; Skin changes; Changed libido; Trouble or pain with sex.
FOR WOMEN: Irregular bleeding; Problems with periods; Lumps in breasts; Vaginal dryness; Hot flashes.
FOR MEN: Erection problems; Lumps or pain in testicles.

FAMILY MEDICAL HISTORY:

Mother_____
Father_____
Siblings_____
Grandparents_____Other_____

LIFESTYLE AND SOCIAL LIFE:

How many cups or glasses do you drink per day? water:_____ caffeinated beverages:_____
What else do you drink and how much?_____
How many alcoholic beverages do you drink per week? _____
Tobacco (type, how much & how long)? _____
How much exercise do you get per week & what kind? _____
_____
_____
How many hours of sleep do you get each night? _____ Do you feel rested in the morning?_____
Have you had any recent major life changes?
_____
_____
What do you do for fun and relaxation?
_____
_____
With Whom do you live?_____
_____ Do you feel safe at home? YES NO
Are you? Employed____ Unemployed____ Disabled____ Other_____
What do you do for work?
_____

Name:_____ Date of Birth_____

WHAT ARE YOUR HEALTH AND HEALING GOALS? WHAT ARE YOUR GOALS FOR THIS VISIT?

_____

_____

_____

THE FOLLOWING SECTION IS USED FOR RESEARCH – WE APPRECIATE YOUR RESPONSES!

PLEASE CHOOSE 1 OR 2 SYMPTOMS (PHYSICAL OR MENTAL) THAT BOTHER YOU THE MOST.

Write them on the lines. Now consider how bad each symptom has been, on average over the last week, and score it by circling your chosen number.

Symptom 1._____ 0 1 2 3 4 5 6

Symptom 2._____ 0 1 2 3 4 5 6

(0 = as good as it could be) (6 = as bad as it could be)

Please choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

Activity:_____ 0 1 2 3 4 5 6

(0 = as good as it could be) (6 = as bad as it could be)

How would you rate your general feeling of wellbeing during the last week?

0 1 2 3 4 5 6

(0 = as good as it could be) (6 = as bad as it could be)

integr
Health, LLC

Dustin Sulak, D.O.
170 US Route 1, Suite 200
Falmouth, ME 04105
O:(207) 482-0188 F: 888-642-8601

NEW PATIENT INFORMATION and CONSENT FORM

Patient's name_____ M____ F___ Birth Date _____

Patient's address _____

_____

Email:_____

Telephones: home_____ work_____ cell _____

single___ married___ other___ children _____

Occupation _____

Patient's employer or school _____

Patient's Primary Care Physician (and/or Referring Physician) _____

Emergency Contact Info:

Name: _____ Relationship: _____ Phone: _____

Referred by: _____

I, _____ understand that payment for services by this office is solely my responsibility, regardless of any insurance coverage I may have. I authorize the release of any medical or other information necessary to process insurance claims, or a release of records to medical review agencies as required by law. I voluntarily and knowingly consent to and request outpatient treatment, which may encompass diagnostic tests and medical treatments deemed appropriate by the treating physician. I understand that such services are to be performed by the attending physician or by assistants designated by said doctor. I further authorize and consent to assistants and other personnel, to undertake this service and care as indicated by my attending physician.

_____ _____

Signature of Patient, Parent or Guardian Date

Integr8 Health, LLC
170 US Route 1, Suite 200
Falmouth, ME 04105
Office 207-482-0188 Fax (888) 642-8601

CONSENT TO TREATMENT WITH MARIJUANA FOR MEDICAL PURPOSES

I, _____, ("Patient") am requesting Dustin Sulak, D.O. or another Integr8 Health, LLC Physician (the "Physician") to certify *(Circle One)* **me /my child/ my legal ward** as a qualifying patient under the Maine Medical Marijuana Act and to treat Patient's debilitating medical condition as Patient uses marijuana for medical purposes. In requesting the Physician to continue treating Patient as Patient uses marijuana for medical purposes, I assume full responsibility for any and all risks of this action related to Patient's current medical condition.

I understand that marijuana is not approved by the Federal Food and Drug Administration for medicinal purposes and may contain unknown quantities of active ingredients and may potentially contain contaminants and/or impurities. I understand that the Physician may not be knowledgeable of all the associated risks involved in the use of a non-FDA approved substance such as marijuana. I acknowledge that there is controversy in the medical/scientific literature available regarding the usage of marijuana for medical purposes and that more research is currently being conducted.

I understand that although the Maine law has approved the limited use of marijuana for medical purposes, its use is not approved under federal law, and that the current and future enforcement action of federal law enforcement officials is uncertain.

I have been truthful with the physician concerning my symptoms and condition. I acknowledge the physician's instruction not to engage in hazardous activities while under the influence of marijuana. I will not engage in the diversion of marijuana, and that the protections of the Maine Marijuana Law apply only within Maine.

_____ _____

Signature of Patient or Patient's Parent/Legal Guardian Date

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Dustin Sulak, D.O.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies and Procedures from Integr8 Health LLC.

I authorize Integr8 Health, LLC to review and discuss my medical information with the following individual(s): (Leaving blank will only allow us to speak with you directly.)

_____ _____
Full Name Relationship & Phone Number

_____ _____
Full Name Relationship & Phone Number

I authorize the physician to confirm my certification upon being contacted for verification by law enforcement, dispensaries and/or caregivers. I release the physician from claims for breach of privacy for so confirming. A verification request may occur through phone, mail, and/or Internet.

_____ _____
Signature of Individual Date

In the event this request is made by the individual's personal representative:

_____ _____
Signature of Patient or Patient's Parent/Legal Guardian Date

_____
Legal Authority of Personal Representative

Integr8 Health, LLC
Cancellation/No Show Payment Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we were unable to schedule you for a visit, due to a full schedule.

Cancellations

It is our policy that all appointments must be cancelled at least 48 hours in advance of the appointment. If an appointment is not cancelled 48 hours in advance, you will be charged the full appointment cost. **Your credit/debit card on file will automatically be charged on the day of the cancellation if you are cancelling less than 48 business hours prior to your appointment.** All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for late cancellations.

No Show

Patients who "No Show" their visit will be charged for that visit, AND will need to prepay future appointments. **Your credit/debit card on file will automatically be charged on the day you "No Show" your appointment.** All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for not showing for their scheduled appointment.

6 Month Follow up Visits

Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider. **Patients who miss the 6 month follow up visit will be charged the full $200 for the recertification visit instead of the discounted $150 amount.**

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We request you come 30 minutes early to your appointment to account for traffic and to complete the required paperwork. If you are 15 minutes past your scheduled time, your provider may not be able to complete a full visit or we will do our best to accommodate you and fit you into the schedule later in the day. **If you can not complete your visit you will be charged for the full visit and you will be required to book a new visit.**

Account Balances

We will require that patients pay their account balances to zero (0) prior to receiving further services by our practice.

Confirmation Policy

You will receive an email and a text message 3 days prior to your appointment that will ask you to confirm your appointment electronically. If your appointment has not been confirmed electronically, you will receive a phone call from our office asking you to call our office to confirm your appointment. **If you DO NOT call our office back by the time requested to confirm your appointment, your appointment will be cancelled. When the appointment is cancelled, you will receive an additional call from our office confirming that your appointment has been cancelled.**

Acknowledgement of Receipt of Cancellation/No Show Policy

I, _____do hereby acknowledge receipt of a copy of the Cancellation and No Show Payment Policy of Integr8 Health, LLC

Signature_____ Date_____

Authorization to charge my credit/debit card

I, _____authorize Integr8 Health, LLC to keep my credit/debit card information on file and charge my credit/debit card in the event that I do not cancel my appointment with a 48 business hour notice OR no show for my appointment.

Signature_____ Date_____

Patients not authorizing Integr8 Health, LLC to keep their credit/debit card information on file will be required to prepay all follow up and recertification visits.

Revised 8.1.15