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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

FOLLOW UP VISIT – HEALTH HISTORY

Name: _____ Date of Birth: _____ Age: _____

Please update your information:

Address: _____

_____

Home phone: _____ **Cell:** _____

Email: _____

PLEASE STATE YOUR CURRENT HEALTH CONCERN(S):

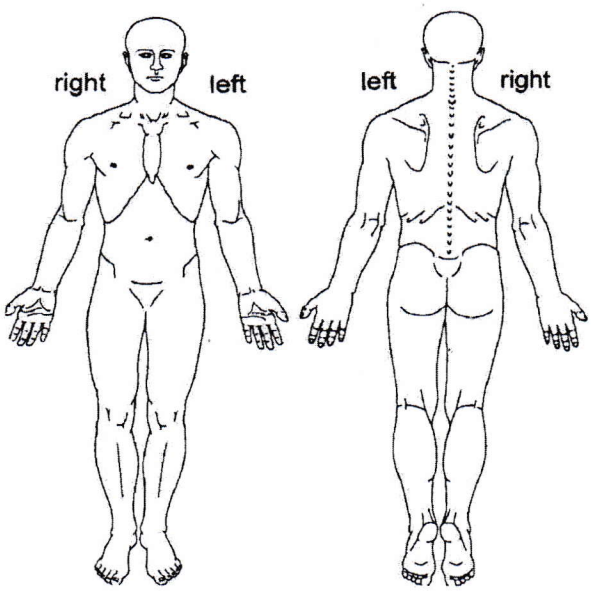
_____

_____

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.



PLEASE DESCRIBE ANY CHANGES IN YOUR HEALTH CONDITION(S) AND QUALITY OF LIFE SINCE YOUR LAST VISIT:

_____

_____

_____

_____

Name:_____ Date of Birth_____

HAVE YOU SEEN ANY NEW PROVIDERS OR TRIED ANY NEW TREATMENTS FOR THIS CONIDITION SINCE YOUR LAST VISIT?

_____

_____

_____

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

Please mark * next to any changes since your last visit

_____

_____

_____

_____

_____

HAVE YOU HAD ANY CHANGES IN YOUR LIFESTYLE OR SOCIAL LIFE (including sleep, diet, physical activity, work, relationships, home life, tobacco use)?

_____

_____

_____

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? (eg. 2 puffs twice daily, or 1/4 ounce per week)

_____

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_____

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)

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