*Please return this form to our office or email to Lea Wetzell lwetzell@synergyfamilyphysicians.com two business days before your first appointment. (Note this is a private, but non-secure email address)

SYNERGY Family Physicians

Name:_____

DOB:_____

Health Goals: _____

What do you hope to achieve in your visit?

How would you rate your current health?

Excellent/Very Good/Good/Fair/Poor

List your three main health/nutrition concerns:

1.

2.

3.

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Allergy Information

Please list food allergies:

Please list non-food allergies including medications/supplements:

Please list environmental allergies:

What type of allergic symptoms do you experience?

Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, mental illness or addiction, etc.*

Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Known Genetic Disorders:	
Comments:	

Medical History

Please check health conditions that your doctor has diagnosed and provide the date of onset

Gastrointestinal	Now	Past	Inflammatory / Autoimmune	Now	Past
Celiac Disease			Chronic Fatigue Syndrome		
Crohn's Disease					
Gastric or Peptic Ulcer Disease			Epstein-Barr Virus		
GERD/heartburn/reflux			Graves' Disease		
Irritable Bowel Syndrome			Gout		
Liver Disease			Hashimoto's thyroiditis		
Small Intestinal Bacterial Overgrowth			Herpes		
			Lupus SLE		
Ulcerative Colitis			Poor Immune Function (frequent infection)		
Other:					
			Rheumatoid Arthritis		
Respiratory	Now	Past	Other:		
Asthma			Musculoskeletal / Pain	Now	Past
Bronchitis					
Chronic Sinusitis			Chronic Pain		
Emphysema			Fibromyalgia		
Pneumonia			Migraines		
Sleep Apnea			Osteoarthritis		
Tuberculosis			Other:		

Cardiovascular	Now	Past
Atherosclerosis		
Elevated cholesterol		
Heart attack		
High blood pressure		
Irregular heart beat		
Mitral Valve Prolapse		
Other:		

Neurological/Brain	Now	Past
ADD/ADHD		
Alzheimer's disease		
ALS		
Anorexia		
Anxiety		
Asperger's		
Autism		
Bulimia		
Eating disorder, Unspecified		
Memory problems		
Parkinson's disease		
Seizures		
Stroke		
Other:		

Urinary / Gynecological *For men and women*	Now	Past
Kidney Stones		
Prostate problems		
Urinary tract infection (UTI)		
Yeast overgrowth/infection		
Other:		

Cancer	Now	Past
Cancer *(please describe type and treatment)*		

Metabolic / Endocrine	Now	Past
Diabetes - Type 1 - Type 2		
Hypoglycemia		
Hypothyroidism (low thyroid)		
Hyperthyroidism (over active thyroid		
Infertility		
Metabolic Syndrome (pre-diabetes, insulin resistance)		
Polycystic Ovarian Syndrome (PCOS)		
Other:		

Dermatological	Now	Past
Acne		
Eczema		
Psoriasis		
Rosacea		
Skin Rash		
Other:		

Describe any additional health concerns or medical diagnoses:

Oral History

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N *If yes, how many?*

Do you have any? ☐ Gold fillings ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have? ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems ☐ TMJ Oral thrush ☐ Swallowing problems ☐ Other, *please describe:*

Women: *please check any that pertain*

	PMS		Irregular periods
	Painful periods		Loss of periods
	Birth control pills (past or present use)		Loss of libido
	Menopause		Painful intercourse
	Hysterectomy		Children
If children, how many and ages:			

Men: *please check any that pertain*

	Frequent urination		Prostate enlargement
	Loss of libido		Difficulty with erections
	Difficulty with urination		

If appointment is for your child:
Please describe his/her concentration, activity level, and behavior:

_____

_____

_____

Diagnostic Studies

Please list any diagnostic studies (example: CT scan, MRI, bone density, colonoscopy, etc, and provide data and age if known).

Birth History

Your Birth: Natural/Vaginal C-Section ☐ Unknown

Were you breastfed as an infant? ☐ Y ☐ N

How would you rate your health as a child? ☐ Good ☐ Fair ☐ Poor

Diet Review

Describe a typical day's meals (include all foods eaten, drinks, and times consumed). Be as specific as you can.

How many times do you eat per day? _____

Breakfast/time: _____

_____

Lunch/time: _____

_____

Dinner/time: _____

_____

Snacks/time(s): _____

_____

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? Yes / No

Do you often skip meals? Yes / No

If yes, which meal do you most commonly skip? _____

What time(s) of the day are you most hungry? _____

What time(s) of the day are you most hungry? _____

What are your favorite foods? _____

What foods do you strongly dislike? _____

How often do you eat out? _____

Which restaurants? _____

Do you eat: Alone / With friends / With spouse/significant other

Do you crave… *(Check all that apply)*

	Sugar		Fat		Fried foods
	Dessert		Bread		Milk
	Meat		Chocolate		Alcohol
If other, please list:					

Do you consume… *(Check all that apply)*

	Butter		Vegetable oil		Peanut oil
	Olive oil		Mayonnaise		Crisco
	Soybean oil		Margarine		Canola Oil
	Corn oil		Coconut oil		
If other, please list:					

Are you sensitive to any of the following foods? *(Please check all that apply)*

	Gluten		Soy		
	Dairy		Nuts		
If other, please explain:					

Nutrition History

Have you ever had a nutrition consultation? ☐ Y ☐ *N* *If yes, date & describe outcome:*

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N *Please describe:*

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N *Please describe:*

Do you avoid any particular foods or beverages? Y N *If yes, what do you avoid and explain why?*

Fluid Intake

Beverages	What type?	How many 8oz per day/week?
Water		
Coffee		
Soda		
Fruit Juice		
Tea		
Alcohol		

Health History

Are you under a physician's care for a chronic health problem that requires continuous monitoring? Yes / No

If yes, please explain: _____

_____

Please list your current medications and the health conditions for which you are taking them for:

Medication:	Health Condition:

How often do you have a bowel movement? _____

How often do you urinate? _____

How is your dental health? Good / Fair / Poor

Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke:
Moderate to severe symptoms / Mild symptoms / No symptoms

Antibiotic use:

	Less than once a year		More than 2 times a year		Hardly ever		Never

Reason for antibiotic use: _____

Steroid use: (Cortisone or Prednisone):

	Frequent		Rare		Never

Do you have a family history of addition?

	Alcohol		Drugs or Medications		Food		Tobacco

Please feel free to expand on any concerns you feel are relevant to your health: _____

_____

_____

Lifestyle Factors

Occupation/Work hours: _____

Do you smoke? Yes / No

Have you recently quit smoking? Yes / No

Do you exercise? Yes / No

If yes, what kind and how frequent? _____

Any problems sleeping? _____

How much sleep do you get each night on average? _____

Please rate the following: *(Circle answer that applies)*

Daily energy level: Excellent / Good / Fair / Poor

Daily stress level: Very High / High / Moderate / Low / None

Energy after exercise: Excellent / Good / Fair / Poor / Not applicable

General enjoyment of life: Excellent / Good / Fair / Poor

Do others consider you: Inactive / Active / Very Active

Are you: Often tired / Occasionally tired / Rarely tired

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged use or regular use of opioid pain killers? ☐ Y ☐ N

Have you had prolonged or regular use of PPI's or acid-blocking drugs (Tagamet)? Y☐ N ☐

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long term antibiotics? ☐ Y N ☐

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

☐ Fast eater	☐ Love to eat	☐ Struggle with eating issues
☐ Erratic eating patterns	☐ Love to cook	☐ Emotional eating
☐ Eat too much/overeat	☐ Family members have different dietary needs	☐ Eat fast food frequently
☐ Late night eating	☐ Live or often eat alone	☐ Poor snack choices
☐ Rely on convenience items	☐ Time constraints	☐ Do not plan meals or menus
☐ Associate symptoms with eating	☐ Drink too much alcohol	☐ Travel frequently
☐ Negative relationship with food	☐ Addicted to sugar/sweets	☐ Confused about nutrition advice
☐ Dislike healthy food	☐ Eat too many processed carbs: breads, pastas, chips	

Health Survey

Rate each of the following symptoms based upon your health profile for the past 6 months. Add up totals for each of the sections.

Point scale:

0 = Never or Almost never have the symptoms
1 = Occasionally have it, effect is Not Severe
2 = Occasionally have it, effect if Severe
3 = Frequently have it, effect is Not Severe
4 = Frequently have it, effect is Severe

Digestive Nausea or vomiting Diarrhea Constipation Bloated feeling Belching, passing gas Heartburn **Total =**	**Ears** Itchy Ears Earaches, ear infections Drainage from ears Ringing in ears Hearing loss **Total =**	**Emotions** Mood swings Anxiety, fear, nervousness Anger, irritability Depression Acting out, aggressive **Total =**
Eyes Watery, itchy eyes Swollen, red, or sticky eyelids Dark circles under eyes Blurred or tunnel vision **Total =**	**Heart** Skipped heartbeats Rapid heartbeats Chest pain Shortness of breath **Total =**	**Lungs** Chest congestion Asthma, bronchitis Difficulty breathing **Total =**
Mind Poor memory Confusion Poor concentration Poor coordination Difficulty making decisions Stuttering, stammering Slurred Speech Learning problems **Total =**	**Mouth / Throat** Chronic coughing Gagging, clears throat frequently Sore throat, hoarse Cavities, tooth decay Swollen, discolored tongue, gums, or lips Canker sores **Total =**	**Nose** Snoring Stuffy nose Sinus problems Sinus drainage Allergies Sneezing attacks Excessive mucus **Total =**
Skin Acne Hives Rashes Dry skin **Total =**	**Head** Headaches Faintness Dizziness **Total =**	**Joint / Muscles** Pain or aches in joints Arthritis Stiffness, limited movement Muscle cramps Weakness or tiredness **Total =**

Health Survey Cont.

Weight Binge eating or drinking Craving certain foods Excessive weight Compulsive eating Water retention Underweight Insulin resistant / pre-diabetic **Total =**	**Low Energy** Sluggishness, low energy Lack of interest, apathy Difficulty waking Can't stay awake Feeling tired or weak **Total =**	**Excess Energy** Hyperactive Restless, fidgety Out of control **Total =**
Hormonal Delay puberty Premature puberty PMS, cramps Hot flashes / night sweats **Total =**	**Sleep** Difficulty falling asleep Difficulty staying asleep Sleep walking Nightmares Bedwetting Insomnia **Total =**	**Other** Frequent illness Frequent or urgent urination Genital itch, discharge **Total =**
Add up the totals for each section to arrive at the grand total. **Grand Total =**		

***If weight loss is one of your goals, please complete the following questions.**

Do you feel you feel you've always had a weight problem? Yes / No

If yes, around what age did you first notice that you had gained weight? _____

What do you feel you weight gain was caused by? _____

_____

What diets have you tried in the past? _____

_____

Have you ever had any health problems as a result of dieting? Yes / No

If yes, what problems? _____

_____

What other cravings do you have? _____

Waiver and Release of Liability, Privacy Practices & Payment Terms & Policy

Waiver and Release of Liability

I agree and understanding that during and after participating in nutrition counseling from Synergy Family Physicians:

- ☐ **I understand that Synergy Family Physicians provides no guarantee or assurances that through nutrition counseling I will achieve my wellness goals, lose weight or overcome or avoid health issues, such as cardiovascular disease or diabetes.**
- ☐ **I assume all responsibility and any risks associated with the nutritional choices that I make. I agree to hold Synergy Family Physicians and it's counselors harmless and release them from any liabilities associated with recommendations and information given by them to me relating to dietary changes or nutritional supplements. I specifically recognize and agree that I have been advised by Synergy Family Physician that dietary changes and/or the taking of nutritional supplements may have differing effects on individuals. I understand that with respect to changes in my diet or in my nutritional practices it is recommended that I consult with my physician.**
- ☐ **I understand that the nutritional counseling provided is not considered to be medical advice and that I am encouraged to continue to pursue medical care with my health care provider.**

Privacy Practices

You have the right to review Synergy Family Physicians Notice of Privacy Practices.
http://www.synergyfamilyphysicians.com/wp-content/uploads/2018/10/Privacy-policy.pdf

- ☐ **I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices.**
- ☐ **I consent to the release of my health records and other information related to healthcare services received at Synergy Family Physicians for the purpose of treatment, payment, and healthcare operations. The Notice of Privacy Practices describes such uses and disclosures more completely, We are required to obtain your consent before we release your health records to other providers.**
- ☐ **I understand that this consent will continue forever unless it is canceled by writing and sent to Synergy Family Physicians at 4422 White Bear Avenue, White Bear Lake, MN 55110.**

Payment Terms & Policy

For private-pay appointments, payment is due at the end of each appointment.

For insurance appointments, deductibles, co-pays, and co0insurance payments are due after the Explanation of Benefits is available. If Synergy Family Physicians submits a claim to insurance and your claim is denied, you will be responsible for the full insurance rate.

Synergy Family Physicians accepts cash, checks, VISA, MasterCard, Discover, and American Express.

Any past due accounts over 90 days will be sent to a collection agency.

Having read and understood the above statements and having had the opportunity to ask questions regarding the meaning and effect of this Waiver and Release of Liability, Privacy Practices & Payment Terms & Policy, my signing is voluntary.

- ☐ **I agree with the terms.**

Date: _____

Signature of Participant or Guardian: **_____**

A. Notifier: Synergy Family Physicians

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Medical Nutrition below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Medical Nutrition below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
97802 - Medical Nutrition initial visit- 15 min per unit, total 8 units - 97803 - Medical Nutrition Follow-up Visit 15 min per unit, total 4 units	Not medically necessary	97802 - $265.00 97803 - $110.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Medical Nutrition listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Medical Nutrition listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Medical Nutrition listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** Medical Nutrition listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.