THE KNIGHT CENTER FOR INTEGRATED HEALTH

DATE:	NAME:	DATE OF BIRTH:

Welcome! Please list the reason(s) or goals for today's visit. READING THE FOLLOWING AND FILLING OUT THE RIGHT FORMS ***HELPS US STAY ON TIME***. HELP HER HELP EVERYONE IN A FAIR AND RESPECTFUL MANNER. IF EVERYONE SURPRISES HER WITH UNEXPECTED REQUESTS WE ALL SUFFER!

- ☐ NEW INJURY OR PAIN? ***REQUEST A GREEN SHEET FROM FRONT DESK.*** LIST THE INJURY OR PAIN below.
- ☐ NEW TESTING OUTSIDE OF OFFICE, **X-*RAYS, CONSULTATIONS YOU WANT TO DISCUSS WITH Provider. Can't be handled in a GO unless pertain to the today's issue, if so must tell front desk at check in so she can relay info to Ian or Jess to pull information. In the future, please tell us when making the appointment.***
- ☐ END OF DAY "GO" APPTS- ***READ THE BACK OF YOUR CLIPBOARD. THEY ARE FOR ONE ISSUE ONLY!!!! DESCRIBE YOUR PROBLEM BELOW. Helps greatly, to answer when did it start, what order did the symptoms appear, anything help, anything make it worse. Anyone else in family or work with same symptoms.***

Refill or Acute Problem Go VISIT

GO	

Please list any medications needing to be refilled **within the next 90 days**, indicate WHERE to send, local pharmacy or mail order. When you request at appointment instead of relying on pharmacy or Jessica you free up Jessica's time to work on prior auth's, answer questions and schedule testing. BE RESPONSIBLE. Know your meds. YOU SHOULD CARRY A LIST OF YOUR MEDICATIONS ON YOUR PERSON AT ALL TIMES!

MEDICATION REFILLS

1	Δ PHARMACY Δ MAIL ORDER
2	Δ PHARMACY Δ MAIL ORDER
3	Δ PHARMACY Δ MAIL ORDER

The following questions (below and on the back of the page) are to review symptoms you are experiencing currently or in past 6 months. **Please circle any current symptoms TWICE.** It is important that you go through each category even if it does not seem to apply to the purpose of your visit.

☐ Check this box if no change in your REVIEW OF SYMPTOMS since last time

GENERAL Fever | Chills | Sweats | Appetite Loss | Fatigue | Sleepiness | Sleep Problems | Recent Weight Gain | Recent Weight Loss | Not Satisfied with Weight

EYES Eye Pain | Vision Loss | Excessive Tears | Sensitive to Light | Itching | Blurring | Double Vision | Dryness | Discharge

EAR/ NOSE/ THROAT Earache | Discharge | Ringing | Excess Wax Hearing Loss | Nasal Congestion | Bleeding | Sinus or Nose Trouble| Sinus Drainage down Throat | Sore Throat | Hoarse | Lost voice Trouble Swallowing | Swollen glands | Stiff neck

HEART Chest Pain | Heart racing | Fainting | Unable to Lay Flat | Swollen Legs | Difficulty Breathing at Night | Difficulty of Breathing Under Exertion | Onset of Chest Pain with Activity vs At Rest

LUNGS Wheezing | Labored Breathing | Frequent sighing Dry Coughing | Excessive mucus when coughing | Coughing Up Blood | Productive Coughing | Pain with inspiration

STOMACH/INTESTINAL Constipation | Diarrhea | Vomiting | Nausea | Heartburn | Abdominal Pain | Change in Bowel Habits | Black Tar-Like Stool | Blood in Stool | Yellowing of skin

GENITOURINARY Frequent Urination | Leakage | Burning | Itching Foul Odor | Genital Sores | Sexually Active | Inability to orgasm Prefer Male | Prefer Female | History of Sexual Abuse| Decreased Libido | New Sex Partner within Last 12 months| **Genitourinary Female Specific** Vaginal Discharge| Abnml Bleeding| Dryness | Painful intercourse | Frequent UTIs **Genitourinary Male Specific** Difficulty Achieving Erection vs Keeping Erection | Lump in Scrotum | Dribbling | Difficulty Starting Urination

SKIN Rash | Itching | Ulcers or Growths | Excessive Scarring| Acne Lumps| Bleeding Problems | Dryness | Lesion that won't heal

MUSCLES/BONES Back Pain | Joint Pain | Joint Swelling | Muscle Cramps | Muscle Weakness | Stiffness

PLEASE CONTINUE ON THE BACK

EMOTIONAL/COMPREHENSION Anxiety | Depression | Insomnia Memory Loss | Thoughts or Attempts of Suicide | Anxiety |Hallucination |Paranoia | Mental Disturbance

NERVOUS SYSTEM Headaches | Fainting |Seizures |Weakness Numbness-Tingling | Transient Paralysis | Vertigo | Tremors

BLOOD/LYMPHATIC/BREASTS Abnormal Bruising | Bleeding Enlarged Lymph Nodes |History of Anemia |Lower Leg Swelling Arm Swelling | Breast Lumps or Tenderness Drainage from Nipple | Monthly Breast Exams? (Y N)

HORMONAL Excessive Thirst | Excessive Eating | Excessive Urination | Cold Intolerance | Heat Intolerance | Hair Loss | Hot Flashes or Night Sweats |
Female Specific Heavier-Lighter-Irregular-Absent Period| Uterine-Cervical-Vaginal-Ovarian Problems | Decrease in Tolerance or Results of Exercise | Seeking Pregnancy within the next 12 months (if so, are you on Prenatal Vitamins? Y N)

IMMUNE SYSTEM Hives | Hay Fever | Lyme or tick exposure | Mold exposure | Frequent Infections | HIV Exposure

PERSONAL SAFETY Do you feel safe in your home? Y N | Anyone trying to control you? Y N | Have you been hit, kicked, punched, or threatened by a partner or ex-partner? Y N

EXERCISE WHAT TYPE, HOW OFTEN, HOW LONG
Describe your aerobic/cardio exercise habits:

Describe your strength training exercise habits:

HEALTH SCREENING (if done elsewhere, ex mammograms not done here). Circle any of the following tests, procedures or educational materials you have been given within the last year and tell when:
Colonoscopy | Cologuard | Mammogram | PAP | Prostate Exam | PSA Fasting Blood Sugar | Cholesterol | Thyroid Hormone | Bone Density Electrocardiogram (ECG) | Stress Test | Lung CT scan (smokers or ex) Pneumonia Vaccine | Shingles Vaccine | Tetanus or TDaP
Flu Shot | Smoking Assessment & Cessation Education
Diabetic Specific: Eye Exam | Foot Exam | Urine Dip | At Least Two Lab Draws | Exercise Counseling | Dietary Education
Want to participate in our upcoming Diabetic Education? Y N

SOCIAL
Describe Recent life changes: ______

Are you satisfied with current living arrangement? Y N
Are you satisfied with your current employment? Y N
Do you feel you have adequate income? Y N

FOR OFFICE USE ONLY

BP: ______ (Cuff Size) P: ______ R: ______ T: ______ Ht: ______

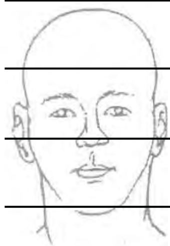
Wt: LMP: Last Mammo: ______ Last Pap: ______

Gyne: ______ Colorectal: ______

Smoker? Y N New Family or Social Hx? ______

O: General: ______

Skin: ______

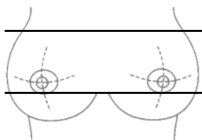


HEENT: ______

Neck: ______

Cardiac: ______

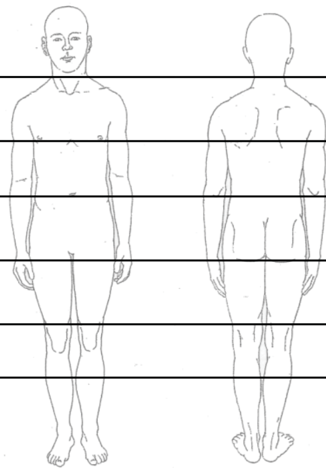
Lungs: ______



Breasts: ______

Abd: ______

Back: ______



Pelvic: ______

Rectal: ______

Ext: ______

Musculoskeletal: ______

Neuro: ______

Mental Status ______

Assessment:	Plan:
1.) ______	1.) ______
2.) ______	2.) ______
3.) ______	3.) ______
4.) ______	4.) ______

⌋ Disposition Entered IN PRAXIS

⌋ Disposition Written on Exit Sheet

⌋ PLEASE ADD CIRCLED INFO TO NOTE IN PRAXIS

⌋ PLEASE ADD CODING 99214 99215 99204 99205 99203 99213

⌋ Add 'l Labs if possible today: ______

⌋ JB to arrange (waiting for appt or she will call):