THE KNIGHT CENTER FOR INTEGRATED HEALTH

4300 N. Brandywine Dr • Peoria, IL 61614 • P 309.692.0123 • F 309.692.0184

Checklist for new patients or prior patients not seen within 3 years:

❖ After you fill out these forms and return them. We will contact you to make the appointments. You can reach our office at 309-692-0123 or ruth@theknightcenter.com to check on the status of your appointment but in general Dr. Knight reviews the new patient packets once a week and then they are booked. We try to book in the order received so please return our call quickly, so we can move on to the next patients and continue booking. If you aren't reached within a week we will move on to the next week of patient's packets.

❖ When you return this packet, please alert us if the visit is for consultation in one of the following areas or other specific condition. If not, we assume it is for Integrated Medicine for Primary Care.

- ☐ Menopause or Women's Hormonal Health
- ☐ Andropause or Men's Hormonal Health
- ☐ Hypothyroidism
- ☐ Osteoporosis
- ☐ Fibromyalgia/Chronic Fatigue
- ☐ Diabetes Mellitus
- ☐ Attention Deficit Disorder
- ☐ Wellness***see below
- ☐ Biotoxin or Environmental Illness#
- ☐ Medical cannabis program/specify qualifying condition: _____

❖ If you are currently needing evaluation for a painful condition or musculoskeletal injury you can also start with our chiropractor, Dr. Ben Miles. Please call back and request an evaluation with him.

❖ Complete the information on the forms attached. Feel free to give us only the last 4 digits of your social security number to protect your number.

❖ If your insurance is an HMO you must make Dr. Knight your PCP and have her name on the card or they may not cover your visit and you will be responsible for the visit payment in entirety.

❖ Dr. Knight will review your information and may select labs that are appropriate for the reason for your visit. If you have had recent labs (within past 3-6 months) elsewhere and want to avoid repeating them you **must attach** those labs to the new patient packet. Any hormone labs will be repeated regardless. She will review them and decide if they are adequate. If you would like any specific tests ordered, please write those on **first page** of the questionnaire. Then we will schedule a lab draw 10-14 days prior to your doctor visit. Some labs require a 3 week turn around.

❖ ***Generally, the new patient appointment usually does NOT qualify for wellness if you have specific health concerns to address or if Dr. Knight is going to be assuming care of chronic conditions that will take more than 50% of our time. However, if you request that it be wellness AHEAD of time and the **majority** of visit is spent discussing preventive health then it may be possible, **remind us you want wellness if you qualify at start of lab draw and visit**. More and more wellness is changing and including very few labs, sometimes all that is covered is cholesterol and blood sugar. BCBS will not consider a new patient visit wellness if any medications are prescribed even if you were already taking them.

❖ It is important to bring bottles/containers of all your medications and supplements to your appointments.

❖ Cancelling an appointment without a 24-hour notice (1 business day) will result in a $100 no-show fee. This must

be paid in full before a new appointment will be scheduled and is NOT applicable towards future fees.

#If you are seeking treatment for a biotoxin related illness such as Lyme disease (which for our purposes includes Borreliosis and other tick-borne infections) or Mold illness from a water damaged building. Then please also on the back of the questionnaire pages or feel free to attach separate pieces of paper, detail a time line of your medical events. In other words, tell me your story from the beginning. And keep it in order as best as you can. Dates you aren't sure of it's okay to estimate. If you are suffering from an illness no one can figure out and you've seen many doctors, then do the same thing.

Just remember go in order of time! That's the best way to tell your life story.

THE KNIGHT CENTER FOR INTEGRATED HEALTH

REGISTRATION INFORMATION

Today's Date: | Primary Care Physician:

PATIENT INFORMATION

Last name: | First name: | Middle name: | Mr. ☐ Mrs. ☐ | Miss ☐ Ms. ☐ | Marital status: S ☐ M ☐ D ☐ SEP ☐ W ☐

Is this your legal name? Yes ☐ No ☐ | If not, what is your legal name? Preferred Pronoun: | Former name (if applicable): | Birth date: | Age: | Gender*: CIS ☐ TRANS ☐ FLUID ☐ OTHER ☐ M ☐ F ☐

SS#: | Cell Phone: | Home Phone: | Hispanic/Latino: Y/N Subrace: _____

Email: | Race: _Originals _Asian _Black _White _Pacific Islander _Other: _____

Street Address / P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone #:

Address: | City: | State: | ZIP Code:

Why did you choose us for your healthcare needs? (check one): Referred by Dr. ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐ Location ☐ Internet search ☐ Ad ☐ If so, where? Other ☐

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the person at the front desk)

Person responsible for bill: | Birth Date: | Address (if different): | Home Phone:

Is this person a patient here? Yes ☐ No ☐

Occupation: | Employer: | Employer address: | Employer Phone:

Is this patient covered by insurance? Yes ☐ No ☐

Primary Insurance:

ID Number:

Subscriber name: | Subscriber SS#: | Birth date: | Group #: | Policy #: | Co-payment: $

Patient's relationship to subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance (if applicable): | Subscriber's Name: | ID or Policy#: | Group #:

Patient's relationship to subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

Insurance Type: Auto ☐ Work Injury ☐ Private ☐ Lien ☐			
Patient's relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐			
Date of Injury:	Describe how injury happened:		
Insurance Company:		Phone:	
Address:		City:	State: ZIP Code:
Policy #:	Claim #:	Workers Comp #:	
Did you report the injury? Yes ☐ No ☐ To Whom:			
Hospitalized? Yes ☐ No ☐	Where?	X-Rays taken? Yes ☐ No ☐	Where?
Were you working at the time of the accident? Yes ☐ No ☐		Dates lost from work:	
Doctors seen for this injury:			
If auto injury, were you: Driver ☐ Passenger ☐ Pedestrian ☐ Other: ☐			
# of people in your vehicle:	Seatbelt worn: Yes ☐ NO ☐	Airbag inflated: Yes ☐ No ☐	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Home Phone:	Work Phone:

*Gender definitions: Cis means you identify as the same gender you were labeled at birth. Trans is an umbrella term that includes all people who have genders not traditionally associated with their assigned sex. Trans female usually means male to female. Trans male usually means female to male. Other terms are non-binary, gender fluid, agender. Agender person doesn't identify with any gender classification. Non-binary or gender fluid means the person doesn't accept a binary system and may identify as multiple genders or between genders. Younger people often call this genderqueer to reclaim the word queer. Intersex individuals have chromosomes or physiology that doesn't conform to the expected configure of either male or female typical bodies. There are many more terms which can be used and can be specified under the other category. Transsexual person has made lasting changes to their physical body, specifically their sexual anatomy through surgery. Not all trans people are transsexual. There are cultures that also identify people that have both masculine and feminine characteristics and presentations as a third gender. Native Americans and Samoans are known to have this third category. Native Americans call them two-spirit persons and Samoans call them fa'afafjne. All the Polynesian languages have similar linguistically related words.

PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing The Knight Center for Integrated Health for your healthcare needs. As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. As a result, some procedures we feel are medically necessary for optimal treatment or preventative care may not be covered by some plans. Due to the differences in various insurance plans and programs, we cannot guarantee that services provided by our practice will be covered under your insurance policy. In addition, our practice may not have a preferred provider agreement with your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. It is your sole responsibility to know and determine what medical procedures your policy includes and excludes including specialists, hospitals, lab tests, x-ray facilities and other medical facilities that are accepted and covered by your insurance plan. To find out what your insurance plan covers and what your financial obligation may be, call the member services department listed on your insurance card. Your employer's human resources department may also be a source of information and assistance.

For the convenience of our patients we accept cash, Visa, Master Card, Discover, traveler's checks, Money Orders and personal checks. Co-payments, co-insurance and deductibles required by individual insurance plans are due at the time services are rendered. We also welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are expected to assume full financial responsibility for all medical services provided. If, for any reason, full payment cannot be made at the time of service, please contact our office to determine if a reasonable payment arrangement can be established.

To be respectful of the medical needs of others we require a 24-hour advance notice of any cancellations. Failure to comply may result in a cancellation fee.

We accept Medicare assignment of covered charges. Patients will be billed for co-insurance, annual deductibles or any uncovered charges unless the patient has supplemental insurance.

Workman's Compensation cases require prior authorization from either the employer or insurance carrier agent before treatment. Should the employer or carrier subsequently deny validated worker's compensation service, such charges will become the financial responsibility for the patient and subject to the terms and conditions outlined in the preceding paragraphs.

In cases of personal injury, we do not defer payment until settlement or judgment. Any patient treated in relation to a personal injury case will be expected to assume full financial responsibility under the terms and conditions outlined in the preceding paragraphs. Claims will be submitted to your insurance company and you will be charged the usual co-payments, co-insurance and deductibles It will be your responsibility to seek personal reimbursement from the sources you feel are responsible. In the case where your health insurance company denies such claims you will be responsible.

RELEASE

I have read the policy regarding my financial responsibility to Knight Medical & Rehab Center, Ltd and Dr. Rebecca A. Knight. I hereby certify that all information I have provided is accurate and true. I authorize payment of any benefits directly to Knight Medical and Rehab Center, Ltd. for all services rendered. If my health plan determines services as not covered, I will be responsible for the all charges. I agree to be responsible for payment of all unpaid services rendered on my behalf or behalf of the above-named patients including any collection fees, attorney's fees or court costs incurred through efforts to collect payment for such charges.

I request that payment of authorized Medicare benefits, if applicable, be made on my behalf to Knight Medical & Rehab Center, Ltd. for services rendered to me by my provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Patient/Guardian signature

Date

THE KNIGHT CENTER FOR INTEGRATED HEALTH

Our approach to health care is different than the conventional model. We utilize a holistic approach and treat mind, body and spirit. We combine the modalities of modern medicine and alternative medicine, often incorporating chiropractic care, massage therapy, nutrition education and exercise in our treatment plans.

FILLING THIS OUT ACCURATELY AND COMPLETELY PRIOR TO YOUR VISIT IS NECESSARY TO MAKE THE MOST EFFECTIVE USE OF OUR TIME TOGETHER.

Name _____ Today's Date_____

Address _____ City, State, Zip _____

Telephone _____ Date of Birth _____ Country of Birth _____

Email: _____ How did you hear about us? _____

My Providers:

Do you have another health care practitioner that you will continue to see for primary care? Yes/No

Are you under the care of any specialists? Yes/No

Please list your providers (including non-allopathic and others helping you in your healing and wellness):

Name	Address	Telephone

Last physical exam: Date _____ Results _____

List 3 main areas or concerns you want to discuss today (If more than 3, multiple appointments may be necessary to adequately cover but certainly go ahead and list them in case they are all related).

1.)

2.)

3.)

My Allergies:

To medications _____

Other allergies _____

Medication intolerances _____

Past Medical History:

Present	Absent		When did it start?	Present	Absent		When did it start?
		Alcoholism				Allergic rhinitis	
		Anemia				Anxiety	
		Arthritis (specify type if known)				Asthma	
		Atrial fibrillation				Chest pain	
		Circulatory system disorder				Congestive heart failure	
		Depression				Diabetes	
		Emphysema or COPD				Gout	
		Headache				Hearing loss	
		Heart attack				Heartburn	
		Herniated Disc				High blood pressure [hypertension]	
		High blood sugar but not DM yet				High lipids	
		Thyroid disease (specify hypo or hyper)				Insomnia	
		Irritable bowel syndrome				Kidney failure	
		Migraine				Mitral valve disorder	
		Osteoporosis				Sinusitis	
		Skin disorder				Stroke	
		Visual impairment				Smoking	
		Fibromyalgia				Menopause	
		Urinary Incontinence				Cancer (specify type)	

Other conditions not listed above:

Past Surgical History and/or Significant Hospitalizations and/or Injuries:

Surgery/Procedure Date Doctor Hospital

Use back of page if need more room

My Family History: (Please indicate maternal or paternal side, M=Mother, F=Father, MGM = Maternal Grandmother, MA= Maternal Aunt, MGA=Maternal Great Aunt if you want to go there, PGF=Paternal Grandfather). Do not include history of spouse or in-laws. Only your blood relatives. If adopted and know your biological family history, please include. Include siblings and children as well as your parents.

Present	Conditions	Family Member (s)	Present	Conditions	Family Member (s)
	Allergic rhinitis			Anemia	
	Anxiety			Arthritis	
	Asthma Aortic aneurysm			Atrial fibrillation Cerebral aneurysm	
	Congestive heart failure			Depression	
	Diabetes			Emphysema or COPD	
	Gout			Headache	
	Hearing loss			Heart attack	
	Heartburn			Herniated Disc	
	High blood pressure (hypertension)			High cholesterol	
	Fibromyalgia			Hypothyroid	
	Insomnia			Alcoholism	
	Kidney failure			Migraine	
	Mitral valve disorder			Osteoporosis	
	Sinusitis			Skin disorder	
	Stroke			Glaucoma	
	Smoking			Cancer (list type)	

My Immunizations:	Had illness			Been immunized		Date last immunized
Rubella (German measles)	Yes	No	Unsure	Yes	No	_____
Rubeola (Measles)	Yes	No	Unsure	Yes	No	_____
Mumps	Yes	No	Unsure	Yes	No	_____
Varicella (Chicken pox)	Yes	No	Unsure	Yes	No	_____
Hepatitis A	Yes	No	Unsure	Yes	No	_____
Hepatitis B	Yes	No	Unsure	Yes	No	_____
Haemophilus influenzae type b	Yes	No	Unsure	Yes	No	_____
Polio	Yes	No	Unsure	Yes	No	_____
Tetanus or TDaP	Yes	No	Unsure	Yes	No	_____
Pneumovax (Strep Pneumonia)	Yes	No	Unsure	Yes	No	_____
Prevnar (Strep Pneumonia)				Yes	No	_____
Meningococcal	Yes	No	Unsure	Yes	No	_____
Shingles	Yes	No	Unsure	Yes	No	_____
Gardasil Series (HPV)	Yes	No	Unsure	Yes	No	_____

My Medications:

Prescriptions (including oral contraceptives):

Prescription Medication (include dose and units such as mcg, IU, ml, mg, gm)		How taken (oral, patch, injected, etc.) and how often once, twice, only as needed		Purpose or diagnosis, reason for taking	✓ if need rf
Name	Dose	How taken	How Often	Reason for Taking	Check

Non-Prescription (i.e. aspirin, laxatives, vitamins, minerals, herbs or nutrients):

Non-Prescription/Supplements	How taken	Purpose

Social Habits:

Tobacco use:

Yes No Former Type _____ Packs/Day (cans or gum) now or before quit ____

Have you tried to quit? Yes No What methods have you tried? □ Cold Turkey □Patches □Gum □ Zyban/Wellbutrin □Chantix □Vape/ECig Other (describe):

Alcohol use:

Yes No Type: Beer Wine Liquor (Circle one you use most) Number _____Per Day/Week/Month

Have you ever felt you should cut down on your drinking? Yes No

Has anyone criticized your drinking? Yes No

Have you felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves? Yes No

Recreational drug use: Yes No Type _____Amount_____

Sexually active? Yes No More than 2 partners in past year (include partner's partners)? Y N Condom use? Y N

Seat belt use: Yes No

Regular dental care: Yes No

Do you know your last cholesterol level (if so, please list)? _____

Fasting Blood Sugar? _____ Blood pressure? _____

Additional Social History

Marital status _____

Children: Yes No (ages) _____

Number of people living in your household? _____

How much formal education have you had? _____

Occupation: _____ How long: _____ Where: _____

Doing what: _____

Please list any major sources of stress in your life: _____

_____

Do you meditate/pray/use relaxation techniques? Yes No (how much and how often) _____

Are you satisfied with your ability to be in a relationship? Why yes or no? _____

Are you having problems getting along with anyone in your family? _____

Have you been hit, kicked, punched, or threatened by a partner or ex-partner? _____

Please list strengths & goals in the following areas:

Physical_____

Mental _____

Spiritual_____

Hobbies and Interests _____

Diet and Exercise Habits

Do you follow a special diet? Yes No (if yes, please describe)
How many servings on milk/milk products do you get per day? _____
Caffeine use? Yes No
Do you exercise? Yes No (if yes, please describe the kind(s) and how often)

Aerobic? _____

Weight resistance/strengthening? _____

Sexually active? (past 3 years) Y N

Women, only, Menstrual and Birth History

First day of last menstrual period _____ Age period began? _____ Length of periods? ___

Length of time between periods (counted from 1st day to day before start) _____

Any recent change in periods?

Last pap test? _____ Any prior abnormal? Y N uncertain Positive for HPV? Y N uncertain

Are you sexually active with opposite sex? Y N

Do you use birth control? Y N

Do you do regular breast self-exam? Y N

Number of pregnancies? ____Abortions, Stillborn, Miscarriages? ___How many Live Births? ____ (details below)

Date of Birth	Weight	Gender	Weeks Preg.	Delivery Type	Any pregnancy complications?
		Male Female			
		Male Female			
		Male Female			
		Male Female			
		Male Female			
		Male Female			

Review of Systems

General

Yes	No	Current	Condition	Comments	See HPI
			Denies fevers, chills, sweats, anorexia, fatigue, sleepiness, sleep problems, malaise, weight gain, weight loss	You may simply check yes on this line if no general complaints	
			Fevers		
			Chills		
			Sweats		
			Anorexia, loss of appetite		
			Fatigue		
			Sleepiness		
			Sleep problems		
			Malaise		
			Recent weight change		
			Weight gain		
			Weight loss		
			Satisfied with current weight		

Eyes

Yes	No	Current	Condition	Comments	See HPI
			Denies eye pain, vision loss, excessive tears, blurring, diplopia, irritation, discharge, photophobia	You can simply check yes on this line if no eye complaints	
			Eye pain		
			Vision loss		
			Excessive tears		
			Itching		
			Blurring		
			Diplopia		
			Irritation		
			Discharge		
			Photophobia (sensitive to light)		

Ear, Nose, Throat

Yes	No	Current	Condition	Comments	See HPI
			Denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia	You can simply check yes on this line if no ear, nose, or throat complaints	
			Earache		
			Ear discharge		
			Tinnitus (ringing or roaring in ears)		
			Decreased hearing		
			Nasal congestion		
			Nosebleeds		
			Sore throat		
			Hoarseness		
			Dysphagia (trouble swallowing)		

Cardiovascular

Yes	No	Current	Condition	Comments	See HPI
			Denies chest pains, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema	You can simply check yes on this line if no cardiovascular complaints	
			Chest pains		
			Palpitations (noticeable abnormal heartbeat)		
			Syncope (fainting or blacking out)		
			Orthopnea (shortness of breath while lying down)		
			Peripheral edema (swelling in legs or feet)		
			Paroxysmal nocturnal dyspnea (waking from sleep unable to breathe)		
			Dyspnea on exertion (shortness of breath during exercise)		

Respiratory

Yes	No	Current	Condition	Comments	See HPI
			Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing	You can simply check yes on this line if no respiratory complaints	
			Trouble with nose or sinuses		
			Wheezing		
			Dyspnea (shortness of breath)		
			Excessive sputum (phlegm)		

Yes	No	Current	Condition	Comments	See HPI
			Hemoptysis (coughing up blood)		
			Cough, productive		
			Cough, dry		

Gastrointestinal

Yes	No	Current	Condition	Comments	See HPI
			Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice	You can simply check yes on this line if no gastrointestinal complaints	
			Constipation		
			Diarrhea		
			Vomiting		
			Nausea		
			Heartburn or reflux		
			Abdominal pain		
			Change in bowel habits		
			Melena (black or “tar-like” stool)		
			History of ulcer		
			Hematochezia (blood in stool)		
			Jaundice (yellow skin)		
			History of liver or gallbladder disease		
			History of binge eating, purging, or laxative use for weight control		

Genitourinary (Female)

Yes	No	Current	Women’s Health Section	Comments	See HPI
			Denies urinary symptoms, vaginal discharge or sores, menstrual irregularity	You can simply check yes on this line if no GU complaints	
			Urinary frequency		
			Incontinence (unable to hold urine)		
			Hematuria (blood in urine)		
			Dysuria (pain when urinating)		
			Frequent urinary tract infections		
			Kidney stones		
			Pelvic pain		

Yes	No	Current	Condition	Comments	See HPI
			Genital sores		
			Vaginal discharge		
			Abnormal vaginal bleeding		
			Amenorrhea (absence of period)		
			Menorrhagia (heavy periods)		
			Vaginal dryness		
			Sexually active		
			Prefer male		
			Prefer female		
			No preference/asexual		
			Bisexual		
			History of sexual abuse		

Genitourinary (Male)

Yes	No	Current	Men's Health Section	Comments	See HPI
			Denies dysuria, nocturia, hematuria, impotence, discharge, hesitancy, incontinence, genital sores, or decreased libido	You can simply check yes on this line if no GU complaints	
			Dysuria (pain when urinating)		
			Nocturia (up to urinate at night)		
			Hematuria (blood in urine)		
			Urinary frequency		
			Urinary hesitancy		
			Penile discharge		
			Genital sores		
			Decreased libido		
			Sexually active		
			Trouble getting or keeping erections		
			Pain or lump in testicles or scrotum		
			Monthly testicular exam		
			New sex partner last 12 months		
			Prefer male		
			Prefer female		
			No preference/asexual		
			Bisexual		
			History of sexual abuse		

Musculoskeletal

Yes	No	Current	Condition	Comments	See HPI
			Denies back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness	You can simply check yes on this line if no musculoskeletal complaints	
			Back pain		
			Joint pain		
			Joint swelling		
			Muscle cramps		
			Muscle weakness		
			Stiffness		

Skin

Yes	No	Current	Condition	Comments	See HPI
			Denies rash, itching, ulcers/growths, excess scarring, bleeding problem, dryness, suspicious lesions	You can simply check yes on this line if no skin complaints	
			Rash		
			Itching		
			Ulcers/growths		
			Excess scarring		
			Bleeding problem		
			Dryness		
			Suspicious lesions		
			Acne		

Neurological

Yes	No	Current	Condition	Comments	See HPI
			Denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo	You can simply check yes on this line if no neurological complaints	
			Headaches		
			Syncope		
			Seizures		
			Weakness		
			Paresthesias (Numbness and tingling sensation)		
			Transient paralysis		
			Vertigo		
			Tremors		

Emotional and Cognitive

Yes	No	Current	Condition	Comments	See HPI
			Denies depression, anxiety, memory loss, mental disturbance, suicidal ideation, hallucinations, paranoia	You can simply check yes on this line if no mental health complaints	
			Depression		
			Anxiety		
			Memory loss		
			Suicidal ideation		
			Hallucinations		
			Paranoia		
			Mental disturbance		
			Insomnia		
			History of hospitalization for psychiatric problems		

Endocrine

Yes	No	Current	Hormonal Health	Comments	See HPI
			Denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change, or hot flashes	You can simply check yes on this line if no endocrine complaints	
			Polydipsia (excessive thirst)		
			Polyphagia (excessive eating)		
			Polyuria (excessive urination)		
			Weight change		
			Cold intolerance		
			Heat intolerance		
			Alopecia (hair loss)		
			Hot flashes or night sweats		
			Amenorrhea (women only-absence of period)		
			Irregular menses (women only)		
			Menorrhagia (women – heavy bleeding)		
			Change in menstrual pattern (women)		
			Pain during intercourse		
			History of uterine, cervical, vaginal, or ovarian problems (women, if yes please)		
			Seeking pregnancy in next year (women, if yes are you on vitamins?)		
			Fatigue		
			Loss of libido (interest in sex)		
			Loss of ability to have orgasm		
			Inability to achieve or keep erection		
			Poor exercise tolerance or decrease response to exercise		

Heme/Lymphatic/Breast

Yes	No	Current	Condition	Comments	See HPI
			Denies abnormal bruising, bleeding, enlarged lymph nodes, anemia	You can simply check yes on this line if no heme/lymph/breast complaints	
			Abnormal bruising		
			Bleeding		
			Enlarged lymph nodes		
			History of anemia		
			Lower extremity lymphedema		
			Lipedema		
			Breast lumps		
			Breast tenderness		
			Drainage from nipple		
			Monthly breast exam		

Allergic/Immunologic

Yes	No	Current	Condition	Comments	See HPI
			Denies urticaria, hay fever, persistent infections, HIV exposure	You can simply check yes on this line if no allergic/immunologic complaints	
			Urticaria		
			Hay fever		
			Persistent infections		
			HIV exposure		
			Lyme (Borrelia) or other co-infections		
			Mold exposure (Water damaged buildings)		

Health Screening

Yes	No	Current	Condition	Comments	See HPI
			Reports Colonoscopy in past year Reports Mammogram in last year, Pap Smear in last year Men: Report Prostrate exam if appropriate for age and race	You can simply check yes on this line if up to date with all your currently recommended preventive health practices	
			Colonoscopy in past year (over 50)		
			Returned hemoccult cards and neg for blood in past year		
			Hemoccult cards given today		
			Mammogram in last year (over 40)		
			Fasting Blood Sugar		
			Pap Smear		

Yes	No	Current	Condition	Comments	See HPI
			Digital Rectal Exam (over 50)		
			Lipid profile		
			Thyroid lab TSH women over 40 and men over 50		
			BMD DXA scan		
			ECG baseline over 50		
			Pneumonia Vaccine at 65		
			Flu vaccine this year		
			Diabetic patient has done eye exam, foot exam, urine dip, and at least 2 blood draws in past year, otherwise exercise counseling, and dietary education within 3 months.		
			Smoking activity assessed and cessation recommended if current smoker		
			Cardio Exercise of at least 30 min 4 times a week		
			Weight lifting 2-3 times a week		
			Shingles vaccine at 60		

Social

Yes	No	Current	Condition	Comments	See HPI
			Recent changes in your life		
			Satisfied with current living arrangement		
			Satisfied with current employment		
			Adequate income		

Any other concerns you wish to discuss (describe)?

Reviewed by: _____ Date: _____

THE KNIGHT CENTER FOR INTEGRATED HEALTH

4300 N. Brandywine Dr • Peoria, IL 61614 • P 309.692.0123 • F 309.692.0184

Authorization to Share Medical Information

Your Right to Medical Information Confidentiality under HIPPA

HIPAA (Health Insurance Portability and Accountability Act of 1996) states if you are 18 years or older, you have the right to strict confidentiality regarding your visits to The Knight Center for Integrated Health. To release any information including the date or nature of your visit, The Knight Center must have your signed consent and specific directions about what information you are consenting to be released. Without written consent, The Knight Center cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, coach and other medical professionals. In addition, you have the right to revoke this authorization at any time. Revocation will be effective when The Knight Center receives written notice that this authorization has terminated. A copy of this document will be kept in your health record. The information disclosed under this authorization risks re-disclosure by a recipient and, as a result, no longer protected to the same extent as required by HIPPA while solely in the possession of The Knight Center for Integrated Health.

Patient's Name (Please Print) _____

Date of Birth: _____/_____/_____

In signing this authorization to release my protected health information I acknowledge that I have read and understand my rights to medical information confidentiality and authorize The Knight Center for Integrated Health to discuss health issues regarding:

_____

_____

_____

With the following listed individuals only:

_____Relationship

_____Relationship

_____
Date Authorization Expires

_____
Signature Date

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info@theknightcenter.com • www.theknightcenter.com

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS

Date: _____ Name: _____

Date of Birth: ___/___/_____(MM/DD/YYYY) Social Security Number: _____-___-_____
(ok to just give last 4 digits)

I hereby authorize the release of records documenting my personal healthcare to be transferred:

To:

The Knight Center for Integrated Health
Rebecca Knight, MD
Ben Miles, DC
4300 N. Brandywine Dr.
Peoria, IL 61614
or Fax to:
309-692-0184

From:

Name: _____

Address: _____

_____

_____

Fax: _____

Please initial below for applicable statements:

( ) Complete Transfer of Care effective: ____/_____/_____
( ) Review only by a consulting physician
( ) Other (please explain) _____
( ) INCLUDE records pertaining to MENTAL HEALTH
( ) INCLUDE records pertaining to HIV
( ) INCLUDE records pertaining to GENETIC TESTING

Patient Signature: _____ Date signed: _____

If minor, Parent or Legal Guardian Signature: _____

If unable to give consent, POA: _____