Morningstar Healing Arts

Please print your information in ink and clearly. Today's date: ________________

Patient's Legal Name:____

Preferred Name: ____ Legal Gender: M / F

Birth date: __________________ Social security # ________ - _______ - _________

Mailing Address: ____

City ___________________________________ State_____________ Zip ________________

Billing Name & Address (if different than above)**:** ______________________________

____

Please circle your primary phone: Home:_________________ Cell: __________________

Work:________________ext._______ Email: ______________________________________

Emergency contact: _________________________________ Phone: ___________________

Relation to contact:____

In case you need a prescription at time of appointment:

Pharmacy:___________________________________**City/Zip**_________________________

Primary insurance: ____ PCP Copay $________

Secondary insurance: ____

If the Policyholder is different from above patient, please print additional information.

Policyholder name: ______________________________________ Birth date: _____________

Patient's Relation
To Policyholder:____

Authorization & Assignment of Benefits

1. I authorize medical treatment for ____ (patient's name)
2. I authorize Howard W. Morningstar, MD, Sue Morningstar, WHCNP, Aja Morningstar, MD and staff to collect and release medical or incidental information as necessary for medical care and for billing insurance on my behalf.
3. I authorize payment of my medical insurance benefits to Howard W. Morningstar, MD and Aja Morningstar, MD for medical services rendered by them or by their staff under their supervision.
4. ***I understand that I am financially responsible for any services provided that are not covered by my medical insurance***. Balances still due 90 days from the date of service will become my responsibility. We will assess a statement charge of $7 per month on past due balances. A $10 billing charge will be applied if we need to bill you for your co-pay.

Signed: ____**Date:** ___________________
(If other than the patient, please state your relation to the patient, i.e. parent, guardian)

Morningstar Healing Arts
Patient Privacy Questionnaire & Instructions

We comply with all Federal and ethical standards to protect your privacy. We will only release information regarding your health care with your written consent and instructions as specified in the following questionnaire.

1. Can we call your **primary telephone number** to leave messages that mention ***only our practice name and the time of your appointment?*** (i.e. an appointment reminder call)

(circle) **YES** **NO**

*Is there an alternative number that we can leave the same type of msg?

(work, cell phone, other)____

2. Can we call your **primary telephone number** to leave messages that ***contain confidential information, such as x-ray and lab results or answers to your medical questions?***

(circle) **YES** **NO**

*Is there an alternative number that we can leave the same type of msg?

(work, cell phone, other)____

3. Please list any individuals with whom we may discuss your medical care:

Name: ______________________________ Phone #: ____________________

Name: ______________________________ Phone #: ____________________

Name: ______________________________ Phone #: ____________________

4. I have received and will review the "HIPPA Notice of Privacy Practices"

Remember, when you filled out and signed your "Authorization & Assignment of Benefits", you also agreed to allow us to collect and release medical or incidental information as necessary for medical care and for billing insurance on your behalf.

These instructions will remain in effect until I ask that they be changed or cancelled.

Patient's Name:____

Signed: _________________________________ **Date:** _________________

(If other than the patient, please state your relation to the patient, i.e. parent, guardian)

Morningstar Healing Arts
Adult Intake Questionnaire

In order to be seen, these forms require completion.

*Please fill out **all five pages** of this confidential questionnaire as completely as you can. Feel free to ask our office staff for help if needed. If you're uncomfortable with any question, it's okay to leave it blank, or talk about it without writing it down. You're welcome to add whatever you feel will be helpful. By helping us know you as a whole person, you help us provide you with the best possible personalized health care.*

PREFERRED NAME: ______________________ Birth date_______________ Today's Date__________

LEGAL NAME/GENDER (needed for insurance)_____________________ ___________________

Pronouns_______________________________ Gender assigned at birth________________________

What is your usual occupation? ______________________________ Are you working now? _______

How did you hear of our medical practice? ____

Main reason for your visit: ____

Other health concerns: ____

____

____

____

Other chronic health problems: ____

____

Any religious restrictions on your medical care: ____

Medication allergies: ____

What other therapies are you using to improve your health or treat a medical condition?

____

List any health care providers you have seen recently, what they were seen for, and treatments used:____

____

Please list dates for any of the following: complete physical______pap/HPV screening__________

Bone density DEXA___________ Tetanus shot ________ Mammogram_______________

Eye exam________Colonscopy/Cologuard (circle)_________cholesterol labs_________

dental exam________HIV test_________Prostate exam__________COVID vaccine_____________

*Please **circle** any of the following that apply to you:*

Poor appetite
Lack of energy
Trouble sleeping
Often sad
Alone in the world
Often anxious
Panic attacks
Trouble concentrating
Frequently angry
Violent behavior
Self-destructive
Frequent injuries
Physical abuse
Emotional abuse
Sexual abuse
Hopeless
Considered suicide
Weight change
Chronic pain
Chronic sores
Hair loss
Fragile nails
Rashes
Acne
Changed mole
Lumps or swelling
Itching or hives
Heartburn
Bloating
Gas or belching
Trouble swallowing
Food intolerance

Nausea or Vomiting
Change in stools
Black stools
Bloody stools
Diarrhea
Constipation
Abdominal pain
Gallstones
Jaundice
Hemorrhoids
Often dizzy
Fainting spells
Frequent headache
Weakness
Numbness
Tingling
Poor coordination
Clumsiness
Tremor
Seizures
Blurred vision
Vision loss
Glaucoma
Itchy eyes
Eye pain
Contact lenses
Hearing loss
Ringing in ears
Ear infections
Earaches
Ear discharge
Hay fever

Sinus problems
Hoarseness
Mouth sores
Dentures
Nosebleeds
Chronic cough
Frequent colds
Neck swelling
Always sweaty
Short of breath;
by day? at night?
Sleep in a chair
Snoring
Wheezing
Coughing blood
Painful breathing
Chest pain
Ankle swelling
Racing heart
Heart murmur
Uneven pulse
Poor circulation
Often feel cold
Often thirsty
Frequent urination
Urgent urination
Painful urination
Flank pain
Bloody urine
Urine infections
Night sweats
Easy bruising

Slow healing
Frequent antibiotics
Blood transfusion
IV drug use
Trouble walking
Joint pains
Swollen joints
Backaches
Sore muscles
Foot pains
Breast lump
Nipple discharge
Decreased libido
Sexual difficulty

Painful testicles
Testicle lump
Penile discharge
Enlarged prostate
Slow urine stream

Irregular periods
Painful menses
Vaginal discharge
Yeast infections
Pelvic pain
Hot flashes
Unexpected vaginal bleeding (even one spot, if after-menopause)

Any other symptoms? ____

____

Have you ever had any of the following? (circle)

Abnormal PAP	Eating disorder	Irritable bowel	Rheumatic fever
Alcoholism	Ear problems	Kidney disease	Seasonal allergies
Anemia	Eczema	Kidney stones	Seizures
Anxiety	Eye problems	Liver problems	Skin disease
Arthritis	Gallbladder disease	Lung disease	Stroke
Asthma	Gout	Mental illness	Suicide attempt
Bleeding problems	Fibromyalgia	Menstrual problems	Thyroid problems
Bone disease	Food allergies	Migraine	Tuberculosis
Broken bones	Frequent headaches	Neurologic problems	Ulcers
Cancer	Frequent infections	Obesity	Vascular disease
Chronic pain	Heart trouble	Osteoporosis	*Others (list):*
Depression	Hepatitis	Pancreatitis	__________________
Diabetes	High blood pressure	Phlebitis	
Digestive problems	High cholesterol	Pneumonia	__________________
Drug abuse	HIV	Prostate disease	

Please give details: ____

____

____

____

Have you ever been hospitalized or had surgery?

When?	Reason for hospitalization or surgery
1 ____________	____
2 ____________	____
3 ____________	____
4 ____________	____
5 ____________	____

Family History

Check here if you are adopted: ________ Do any blood relatives have the following? (circle)

Asthma	Abnormal bleeding	High cholesterol	Heart disease
Allergies	Drug/alcohol dependency	Cancer (kind)	Mental illness (kind)
AIDS	Inherited problems (kind)	Emphysema	High blood pressure
Stroke	Chronic infections	Diabetes	Osteoporosis

Other? ____

Please give details, such as which relative and type of disease if relevant _________________

____

Social History

Do you have any children? _______ Please list the years of their births: _______________________

How many sexual partners in the last year? ______ What genders were they ___________________

Have you ever had a sexually transmitted disease? (list) ______________________________________

Do you always practice "safe sex"? ________

What does "safe sex" mean to you? ____

Contraception? ____________________

Have you ever been sexually or physically assaulted or abused? ______________________________

Do you feel safe at home now? ____

If you ever feel unsafe in your relationship, this is a SAFE space to talk about it.

Relationship status: __________________ Who lives with you at home? (list below)

Name	Age	Relationship to you	Any medical problems?

Have you experienced any major stresses or life changes in the last year?

____

How do you deal with stress?

____

____

____

____

How do others at home deal with stress? ____

Who helps you deal with life's problems? ____

What do you do to relax or have fun? ____

List concerns regarding your physical appearance or habits you wish to change: ______________

____

How many alcoholic drinks do you have daily? _______ weekly? _______

Have you ever felt you needed to cut down on your drinking? _______

Has anyone ever annoyed you by criticizing your drinking? ______

Have you ever felt guilty about drinking? _______

Do you feel you need a drink first thing in the morning? _________

Do you use tobacco now? (circle): cigarettes cigars e-cig pipe snuff chew

How many times a day do you use tobacco? _______ For how many years? ________

Have you ever used tobacco regularly in the past? __________ When did you quit? _____________

Do you use any other drugs socially? ____

Have you ever felt you have overused any drugs? ____

Do you always wear a seat belt? ________ Do you ever drive while impaired? __________________

Are there any unlocked guns in your home? ________

If you use a bicycle, do you always wear a bike helmet? ____________

Do you have a POLST, living will or advanced directive? _______________

Would you like to discuss your wishes regarding end of life care? _____________________________

If you have a uterus: Date of last menstrual period: _________

Number of pregnancies and outcomes: ____

____

Any complications with pregnancy? ____

____

Everyone: Describe a *typical day's diet* (be honest!):

Breakfast: ____

Lunch: ____

Dinner: ____

Favorite snacks: ____

Glasses of water you drink daily: ______________ Other daily drinks: __________________________

Is there anything you wish to add? ____

MEDICATION LIST

Please list ALL medicines that you take including prescription drugs, over the counter remedies, herbs, supplements and vitamins

MEDICATION NAME	DOSAGE	FREQENCY