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: Howard/Sue (v9 2.23)

*Please fill out **all four pages** of this confidential questionnaire as fully 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.*

Today's date: _____**NAME:** _____**Preferred name**_____

Date of Birth: _____Preferred pronouns_____Gender assigned at birth_____

What is the main reason for your visit? _____

Please list other health concerns: _____

_____

_____

_____

_____

List any other chronic health problems: _____

_____

_____

List any religious restrictions on your medical care: _____

List any medication allergies: _____

Have you ever been hospitalized or had surgery?

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

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 were you seen for? _____

What treatments were used? (such as: body work, surgery, diet, behavioral, medications)

_____

_____

Adult Intake Questionnaire: *page 2 of 4*

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
Wake up to urinate (most nights)
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

Men:
Painful testicles
Testicle lump
Penile discharge
Enlarged prostate
Slow urine stream

Women:
Irregular periods
Painful menses
Vaginal discharge
Yeast infections
Pelvic pain
Unexpected vaginal bleeding
Hot flashes

Any other symptoms? (list or describe): _____

_____

_____

Please list dates for any of the following: Wellness visit: _____ PAP screening: _____

Bone Density (DEXA): _____ Tetanus shot: _____ Mammogram: _____ Breast exam____ Eye exam: _____

Colonoscopy: _____ Cologard:_____ Cholesterol labs: _____ Dental exam: _____

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

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

Please give details:_____

_____

_____

Do any blood relatives have the following? (circle) Check here if you're adopted: _____

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

Other serious problems? Please give details _____

_____

_____

Are you? (circle) Single Married Living with partner Separated Divorced Widowed

Women only: Date of last menstrual period: _____ Number of pregnancies: _____

Any complications with pregnancy or birth? _____
Have you ever had a miscarriage or an abortion? (when)_____

Any complications? _____

Have you ever given a baby up for adoption or adopted a child? (when)_____

Men & women: How many children do you have? _____ Please list the years of their births:

_____

How many sexual partners have you had in the last year? _____ Were they (circle) Male Female

Any issues or difficulties with sex? pain or bleeding? Libido? Erectile issues?

_____

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

Do you always practice "safe sex"? _____Do you use any contraception?_____

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

Who lives with you at home? (list below)

Name	Age	Relationship to you	Any medical problems?

Have you experienced any major stresses in the last year? (birth, serious illness, accident or death of family member, moved, new work, financial, relationships or…) *Please list:*

_____

How do you 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 times a day do you use caffeine products (coffee, tea, colas, chocolate):_____

How many alcoholic drinks do you have daily?: _____ or weekly?: _____

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

How many times a day do you smoke? _____ For how many years have you smoked? _____

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

Do you use any other drugs socially? (please list)_____

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

Are there any unlocked guns in your home? _____ Do you have a living will? _____

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

Breakfast: _____

Lunch: _____

Dinner: _____

Favorite snacks: _____

Glasses of water or fluids you drink daily (other than caffienated or soft drinks): _____

What is your usual occupation? _____ Are you working now? _____

Please describe what you do at work: _____

Are you exposed to any toxic materials? (describe) _____

What is the highest grade you completed in school?_____ Are you in school now?_____

How did you hear of our medical practice? _____

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