



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 Page 1 of 4 (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: Howard page 2 of 4

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

- |                       |                    |                    |                      |
|-----------------------|--------------------|--------------------|----------------------|
| Poor appetite         | Nausea or Vomiting | Sinus problems     | Night sweats         |
| Lack of energy        | Change in stools   | Hoarseness         | Easy bruising        |
| Trouble sleeping      | Black stools       | Mouth sores        | Slow healing         |
| Often sad             | Bloody stools      | Dentures           | Frequent antibiotics |
| Alone in the world    | Diarrhea           | Nosebleeds         | Blood transfusion    |
| Often anxious         | Constipation       | Chronic cough      | IV drug use          |
| Panic attacks         | Abdominal pain     | Frequent colds     | Trouble walking      |
| Trouble concentrating | Gallstones         | Neck swelling      | Joint pains          |
| Frequently angry      | Jaundice           | Always sweaty      | Swollen joints       |
| Violent behavior      | Hemorrhoids        | Short of breath;   | Backaches            |
| Self-destructive      | Often dizzy        | by day? at night?  | Sore muscles         |
| Frequent injuries     | Fainting spells    | Sleep in a chair   | Foot pains           |
| Physical abuse        | Frequent headache  | Snoring            | Breast lump          |
| Emotional abuse       | Weakness           | Wheezing           | Nipple discharge     |
| Sexual abuse          | Numbness           | Coughing blood     | Decreased libido     |
| Hopeless              | Tingling           | Painful breathing  | Sexual difficulty    |
| Considered suicide    | Poor coordination  | Chest pain         |                      |
| Weight change         | Clumsiness         | Ankle swelling     | <i>Men:</i>          |
| Chronic pain          | Tremor             | Racing heart       | Painful testicles    |
| Chronic sores         | Seizures           | Heart murmur       | Testicle lump        |
| Hair loss             | Blurred vision     | Uneven pulse       | Penile discharge     |
| Fragile nails         | Vision loss        | Poor circulation   | Enlarged prostate    |
| Rashes                | Glaucoma           | Often feel cold    | Slow urine stream    |
| Acne                  | Itchy eyes         | Wake up to urinate | <i>Women:</i>        |
| Changed mole          | Eye pain           | (most nights)      | Irregular periods    |
| Lumps or swelling     | Contact lenses     | Often thirsty      | Painful menses       |
| Itching or hives      | Hearing loss       | Frequent urination | Vaginal discharge    |
| Heartburn             | Ringling in ears   | Urgent urination   | Yeast infections     |
| Bloating              | Ear infections     | Painful urination  | Pelvic pain          |
| Gas or belching       | Earaches           | Flank pain         | Unexpected vaginal   |
| Trouble swallowing    | Ear discharge      | Bloody urine       | bleeding             |
| Food intolerance      | Hay fever          | Urine infections   | 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: \_\_\_\_\_

**Adult Intake Questionnaire: Howard** page 3 of 4

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

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

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? \_\_\_\_\_

**Adult Intake Questionnaire: Howard** page 4 of 4

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? \_\_\_\_\_

