new power medicine

Medical History and Review of Systems

Date Completed: _____/_____/_____

Patient Information

Patient Name: _____ SSN_____-_____-_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Widower

Individual Completing This Form: _____

Relationship to Patient:_____

Contact Information

Primary Address: _____

City: _____ State: ____ Zip: _____

Secondary Address: _____

City: _____ State: ____ Zip: _____

Occupation: _____ Place of Employment:_____

Home: (____) ____-_____ Business: (____) ____-_____ Cell: (____) ____-_____

Email Address: _____

Emergency Contact _____ Phone: (____) ____-_____

References and Current Condition

Referred By: _____

Primary Care Physician: _____

Other: _____

ARE YOU UNDERGOING MEDICAL TREATMENT? ☐ **YES** ☐ **NO**

If yes, please describe:

Condition: _____

Symptoms: _____

_____

Chief Complaint: _____

_____

Office use

Negative Normal None

Master Medication Sheet

Patient's Name: _____ DOB: ____/____/_____

Date Started	Medication	Dosage	# Per Day

☐ Allergies ☐ No Known Allergies to Medication

To Medicines: _____

_____

Office use

Negative Normal None

Vitamins & Minerals Sheet

Patient's Name: _____ DOB: ____/____/_____

Date Started	Supplement	Dosage	# Per Day	For Office Use

Office use

Negative Normal None

Symptoms:

Allergies:

Animals ☐	Pollens ☐	Dust ☐
Aerosols ☐	Fats ☐	Industrial chemicals ☐
Sugar ☐	Wine/alcohol ☐	Food additives ☐
Dairy products ☐	Antibiotics ☐	Aspirin ☐
Latex sensitive ☐	Medications ☐	Wheat ☐
Eggs ☐		Seasonal Allergies ☐

Allergic Symptoms:

☐ Skin (Describe):

_____

☐ Hay fever:

_____

☐ Asthma

_____

☐ Nasal

_____

Cravings:

Water ☐	Coffee / Tea ☐	Alcohol ☐
Sweets / Chocolate ☐	Tobacco ☐	Salt ☐

General:

Chills ☐	Daytime drowsiness ☐	Fever ☐
Night sweats ☐	Weight gain ☐	Weight loss ☐
Fatigue / Tiredness ☐	Energy dives ☐	Listless ☐
Lack of drive ☐	Shakiness ☐	Sweating spells ☐
Frequent yawning ☐	Dizzy spells ☐	Fade out ☐
Alcohol problem ☐	Difficulty getting up in the morning ☐	

Sleep:

Very light ☐	Heavy ☐	Difficult to fall off ☐
Restless ☐	Disturbing dreams ☐	Dreamless ☐
Frequent wakening ☐		

Office use

Negative Normal None

Eye:

- Blurred vision ☐
- Tearing/Watering ☐
- Spots/Floaters/Flashes ☐
- Cataracts ☐
- Inflamed lids ☐
- Lack of eye fluids ☐
- Itchy ☐
- Eyestrain/Fatigue ☐
- Glare/Halos ☐
- Infection ☐
- Macular Degeneration ☐
- Painful eyeballs ☐
- Eye discharge ☐
- Burning ☐
- Irritation (dry itch, red) ☐
- Double vision ☐
- Glaucoma ☐
- Poor night vision ☐
- Frequently squinting ☐
- Sandy feeling ☐
- Recurring bloodshot ☐

Ears:

- Hearing difficulty/loss ☐
- Discharge from the ear ☐
- History of grommets ☐
- Blocked ears ☐
- Ringing in the ears ☐
- Attacks of vertigo ☐
- Motion sickness ☐
- Ear noises ☐
- Recurring earaches ☐

Nose:

- Nasal blockage ☐
- Postnasal drip ☐
- Loss of smell ☐
- Nose bleeds ☐
- Phlegm ☐
- Recurring nose bleed ☐
- Sinus problems ☐
- Itchy ☐

Throat:

- Frequent sneezing ☐
- Sleep apnea ☐
- Recent change in voice quality ☐
- Frequent sore throat ☐
- Difficulty swallowing ☐
- Snoring ☐
- Hoarse ☐

Tongue:

- Dry ☐
- Inflamed ☐
- Pink ☐
- Furry coated ☐
- Loss of taste ☐
- Sore ☐
- Split ☐
- Purplish ☐
- Bile taste ☐
- Enlarged ☐
- Grooved ☐
- Smooth shiny ☐
- Brilliant red ☐
- Metallic taste ☐

Mouth:

- Canker sores ☐
- Receding gums ☐
- Tender puffy gums ☐
- Blisters ☐
- Receding lip line ☐
- Dry mouth ☐
- Split corners ☐
- Dry cracked lips ☐

Office use

Negative Normal None

Teeth:

- Loose ☐
- White patches ☐
- Discolored ☐
- Bleeding gums ☐
- Grinding teeth in sleep ☐

Cardiovascular:

- Swelling in feet/hands ☐
- High blood pressure ☐
- Weight gain ☐
- Irregular heartbeat ☐
- Angina/chest pain ☐
- Heart Disease ☐
- Carotid Artery Disease ☐
- Fainting ☐
- Heart Attack ☐
- Stroke ☐
- Phlebitis ☐
- Low blood pressure ☐
- Atherosclerosis ☐
- Palpitation ☐
- Coronary thrombosis ☐
- Cold hands ☐
- Cold feet ☐

Lipids:

- High Cholesterol ☐
- High Triglycerides ☐

Respiratory:

- Cough ☐
- Shortness of breath ☐
- Asthma ☐
- Bronchitis ☐
- Pneumonia ☐
- Emphysema ☐
- Tuberculosis ☐
- Pleurisy ☐
- Painful breathing ☐
- Hyperventilation ☐
- Respiratory infection ☐

Immunologic

- Seasonal Allergies ☐
- Itching ☐
- Hives/Rash ☐
- Persistent infection ☐
- HIV ☐
- Recurring infections ☐
- Candidiasis Albicans (Yeast) ☐

Gastrointestinal:

- Ulcers ☐
- Reflux disorder ☐
- Hiatal Hernia ☐
- Nausea ☐
- Diarrhea ☐
- Vomiting ☐
- Appetite loss ☐
- Gallstones ☐
- Cramps ☐
- Pains ☐
- Spastic Colon ☐
- Crohn's Disease ☐
- Diverticulitis ☐
- Flatulence ☐
- Heartburn ☐
- Nausea / biliousness ☐
- Bloating ☐
- Belching ☐
- Gas ☐

Office use

Negative Normal None

Constipation:

Chronic ☐	Recurring ☐	Difficult release ☐
Foul smelling ☐	Irregular ☐	Hard solid stool ☐
Black hard pellet stools ☐		

Laxatives used:

Brand name	Amount taken	Times per day
_____	_____	_____
_____	_____	_____

Diarrhea:

Watery ☐	Bile ☐	Frothy ☐
Oily / Fatty ☐	Frequency: _____	

Genitourinary:

Kidney Disease/Infection ☐	Bladder Problems ☐	Genital Herpes ☐
Painful Urination ☐	Frequent Urination ☐	Blood in Urine ☐
Kidney Stones ☐	No control ☐	Burning urine ☐
Urgency ☐	Cloudy urine ☐	Difficult starting ☐
Venereal Disease ☐	Strong odor ☐	

Office use

Negative Normal None

------ WOMEN ------

Pregnant:

Yes ☐ No ☐

Nausea ☐ Eclampsia (Seizures) ☐ Fluid retention ☐
Ankle swelling ☐ Anemia ☐

Menstrual and Gynecologic:

Hysterectomy ☐ PMS ☐ Cramps ☐
Heavy flow ☐ Normal flow ☐ Menopause ☐
No menstrual cycle ☐ Vaginal discharge ☐ Vaginal thrush ☐
Vaginitis ☐ Leucorrhea ☐ Dysmenorrhea ☐
Trichomoniasis ☐ Itching ☐ Foul smelling ☐
Vaginal infection ☐ I.U.D ☐ Vaginal inflammation ☐

Hormone and sex problems:

Infertility ☐ Lack of libido ☐ Lack of orgasm ☐
Hot flashes ☐ Lack of secretions ☐

------ MEN ------

Hormone and sex problems:

Impotency ☐ Infertility ☐ Loss of erection ☐
Lack of libido ☐ Peyronie's Disease ☐ Gynecomastia ☐
Premature ejaculation ☐

Musculoskeletal:

Arthritis ☐ Gout ☐ Joint pain ☐
Back pain ☐ Lower back pain ☐ Muscle cramps ☐
Joint swelling ☐ Stiffness ☐ Aching muscles ☐
Muscle weakness ☐ Weak ligaments ☐ Leg cramps ☐
Myasthenia gravis ☐ Shin splints ☐ Tennis elbow ☐
Ligament problems ☐ Muscle atrophy ☐ Loss of muscle ☐
Muscle movement pain ☐ Spine curvature ☐ Osteoporosis ☐

Office use
Negative Normal None

Skin problems:

Dry ☐	Scaly ☐	Acne ☐
Eczema ☐	Itchy ☐	Boils ☐
Psoriasis ☐	Vitiligo ☐	Sweaty ☐
Pigmentation ☐	Brown spots ☐	Cancer ☐
Discolored ☐	Rash ☐	Poor healing ☐

Nails:

Ridges ☐	White spots ☐	Peel ☐
Break off ☐	Hangnails ☐	Soft ☐

Hair and scalp:

Dry ☐	Falling out ☐	Brittle / breaks easily ☐
Unmanageable ☐	Thin ☐	Oily ☐
Seborrhea ☐	Dandruff & dry scalp ☐	

Feet:

Athlete's feet ☐	Fungal infections ☐	Bunions ☐
Corns ☐	Toe deformities ☐	Painful feet ☐
Calluses ☐	Thickened nails ☐	Itching ☐

Endocrine:

Diabetes ☐	Excessive Thirst ☐	Liver disease ☐
Hepatitis ☐	Thyroid disease ☐	Heme/Lymphatic ☐
Anemia ☐	Bleeding problems ☐	Fever ☐
Swollen lymph nodes ☐	Yellow jaundice ☐	Rheumatic fever ☐
Gallbladder removed ☐	Gallbladder problems ☐	Gallstones ☐

Do you have Kidney problems? ☐ Yes (if checked, please explain)

_____

Office use

Negative Normal None

History of weight problems:

Frequent dieting ☐	Bulimia ☐	Anorexia ☐
Overweight ☐	Under weight ☐	Cellulite ☐
Fluid retention ☐	Compulsive eating ☐	Difficult to control ☐
Weight control needed ☐		

Neurologic:

Memory loss ☐	Alzheimer's ☐	Speech impairment ☐
Seizures ☐	Tremors ☐	Numbness/Tingling ☐
Weakness ☐	Headaches ☐	Migraines ☐
Dizziness ☐	Hearing loss ☐	Ringing in ears ☐
Pins and needles ☐	Tics ☐	Jerks ☐
Twitching ☐	Poor circulation ☐	Clumsy ☐
Neuralgia ☐	Shooting pains ☐	Tired feet ☐
Burning feet ☐	Parkinson's Disease ☐	Neuritis ☐
Paralysis ☐	Carpal tunnel syndrome ☐	

Emotional:

Depression ☐	Anxiety ☐	Weepiness ☐
Irritability ☐	Impatience ☐	Temper ☐
Poor concentration ☐	No initiative ☐	Anger ☐
Neurosis ☐	Autism ☐	Schizophrenia ☐
Epilepsy ☐	Learning difficulties ☐	

Headaches:

Recurring ☐	Frontal headache ☐	Eye aches ☐
Temple aches ☐	Migraine ☐	With nausea ☐
After stress ☐	After exertion ☐	Back of head/neck ☐

Hospitalization/Surgery: List any previous below:

_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____

Office use
Negative Normal None

Social History:

☐ Tobacco **(Please address if former smoker)** How much AND how often? _____
☐ Alcohol How much AND how often? _____
☐ Recreational drugs How much AND how often? _____

Activity and exercise:

Past _____ Frequency _____
Present _____ Frequency _____

Family History:

Relative	Good health	Poor health	Deceased	If deceased, give age & cause of death
Father	☐	☐	☐	
Mother	☐	☐	☐	
Brother	☐	☐	☐	
Brother #2	☐	☐	☐	
Brother #3	☐	☐	☐	
Brother #4	☐	☐	☐	
Sister	☐	☐	☐	
Sister #2	☐	☐	☐	
Sister #3	☐	☐	☐	
Sister #4	☐	☐	☐	
Spouse	☐	☐	☐	
Child	☐	☐	☐	
Child #2	☐	☐	☐	
Child #3	☐	☐	☐	
Child #4	☐	☐	☐	

Office use
Negative Normal None

FINANCIAL POLICY

Thank you for choosing The Lio Mission/New Power Medicine for your healthcare needs. We are determined to provide you with a high quality of healthcare. Our staff will be happy to assist you with any questions regarding our fees, policies and/or your responsibilities for those fees. Please be sure to notify our front office should there be any issues with your personal information, such as address, phone number or insurance policy changes.

FEES, INSURANCE AND FINANCIAL POLICIES

All co-pays are due at the time of your appointment. We will advise you at the time of your appointment of your copay amount and if known ahead of time, your coinsurance and deductible amounts. Please be prepared to pay for these services at the time of your appointment. Some of these amounts are not determined until payment is received from your insurance company.

INSURANCE CLAIMS AND OUTSTANDING BALANCES

Your insurance benefits are ultimately a matter between you and your insurance company; however, we will file all insurance claims for you and collect their portion. Due to insurance regulations, we are required to send billing statements for the coinsurance amounts due after you insurance pays their portion of our bill. If you have difficulty with your insurance portions, we will be happy to provide the necessary “hardship” forms for you. You will be notified by our staff in the event that you may qualify for assistance with your coinsurance amounts. We are also willing to make payment arrangements with you for any outstanding balance on your account.

SELFPAY ACCOUNTS

There are considerable expenses involved in filing insurance claims. Therefore, we have the ability to offer discounted rates for self-pay. Initial office visit is $125.00 and IV therapy sessions will depend on IV rendered day of service. These charges are due at the time of service. Charges will vary depending on the services provided.

Office use

Negative Normal None

new power medicine

Payment Information
Right to Restrict Disclosure of Protected Health Information
Notice of Privacy Practices

☐ SELF PAY

PRIMARY CARRIER	SECONDARY CARRIER
Insurance Co:	**Insurance Co:**
ID/Policy #:	**ID/Policy #:**

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. Please remember: It is your responsibility to pay any deductable amount, coinsurance and other balances not paid for by your insurance company. If your insurance company does not respond to our billing within 60 days, you are responsible for the charges. **Self-pay and co-pays are due at the time of service.**

Each time you receive care or treatment at The Lio Mission/New Power Medicine, a record of your visit is made. Such record includes protected health information ("PHI") such as your symptoms, examination, test results and diagnoses. In order to bill your health plan for care and treatment provided to you, we must provide your health plan with certain PHI about you. You have the right to request that we not share your PHI with your health plan for any reason, so long as you pay for such items or services out of pocket in full.

Questions and Complaints:
If you have any questions about this notice please contact:
The Lio Mission, Inc.
5454 Central Avenue
Suite C
St. Petersburg, FL. 33707
(727) 498-8608
Privacy Officer: Stephanie Palmer
If you think that we may have violated your privacy rights, contact the person named above. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint. We will not retaliate in any way, if you choose to file a complaint.

ACKNOWLEDGEMENT

By signing this form I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices/Right to Restrict Disclosure of Protected Health Information. I request the Lio Mission/New Power Medicine not disclose any of my Protected Health Information ("PHI") to my health plan without my written consent.
The Lio Mission/ New Power Medicine and its entities are required to agree to a restriction regarding a health care service for which you have paid in full and out of pocket. You must submit payment in full for this restriction to be implemented. If payment is not received in full, this restriction will no longer be valid.

Signed: _____ Date: _____

Office use
Negative Normal None

Waiver and Release from Liability Form

I, _____HEREBY WAIVE AND RELEASE, indemnify, hold harmless and forever discharge The Lio Mission, INC/ New Power Medicine, and its physicians and employees of and from any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages and liabilities, of every kind of nature, whether known or unknown, in law or equity, that I ever had or may have, arising from or in any way related to my participation in any of the treatments or procedures conducted by or on the premises of, or for the benefit of the Lio Mission/New Power Medicine.

I understand that the treatments and procedures that I will participate in are being prescribed or performed in good faith with the intention to help or heal. As such, and as a responsible adult, on behalf of myself or my heirs, assigns and next of kin, I waive all claims for damages, injuries or death sustained by me or my property that I may have against the aforementioned released party to such activity.

By this waiver I assume any risk, and take full responsibility and waive any claims of personal injury or death or damage to personal property associated with the Lio Mission Inc/New Power Medicine associated with my involvement in any organization affiliated with the aforementioned released party.

By my signature on this document I assume all responsibility for and personal injury, death, or damaged property that may occur while I am participating in any activity associated with an affiliated organization. I sign this document on my own accord and not under any duress or threat of duress, without inducement, or harassment. I certify that I am at least 18 years of age and am legally authorized to sign this waiver on my own behalf. I also understand that by signing this waiver I relinquish any right or future right to seek damages against the Lio Mission Inc/New Power Medicine for any harm, personal injury, death, or property damage that may occur while I am participating in authorized Lio Mission Inc/New Power Medicine services.

Signature

Date

Office use

Negative Normal None