Teton Sage New Patient Questionnaire

I _____, do hereby acknowledge that I have received the Teton Sage Notice of Privacy Practices. (Attached to the end of this form)

Signature of patient (or caregiver if less than 18): _____ Date: _____

Confidential Evaluation

The answers provided in the questions below will allow the provider to maintain your medical history and will help in advising about current medical therapies. All information provided is confidential.

General Patient Information

Patient Name: _____ Date of Birth: _____ Sex:_____
Address: _____
Contact Numbers: Home:_____ Cell: _____ Work: _____
Email Address: _____ Height:_____ Weight:_____
Occupation: _____Full-Time _____Part-Time_____Other _____
Who do you live with? _____ Status: Married ___ Single ___ Divorced ___ Widowed____

What are your goals for Therapy? _____
_____
_____
Are you willing to make significant lifestyle and dietary changes – such as eliminating wheat or dairy from your diet? (Depending on your health condition, I may ask you to do this.) Circle one YES NO
What do you believe is the cause of your symptoms/conditions? Why?_____
_____
Where did you hear about Teton Sage? _____

What are the top ten symptoms you are currently experiencing? List in order of irritation and severity for you. Date the onset of each symptom.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medical Conditions (Diagnoses) Please put in date of onset:			

Current Medications (include all vitamins, supplements, and over-the-counter products):	Dose	List time(s) of day usually taken	Approximately when was this started?	Helping? Causing any adverse effects?

For the following procedures, list the last date and results, if applicable.
Bone Mineral Density_____
Colonoscopy_____
Stool culture_____

Current/Recent Health Care Providers and what you saw them for (please include contact information) :
_____
_____
_____
_____

HABITS
Dietary Restrictions: _____
What did you eat in the last 24 hours (list time and what eaten):
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Dou you have a certain food or groups of foods that you crave? If you know why, list that, also:
_____
_____
Do you ever binge on food/drink (If so, list your drug of choice):_____
Do any foods/drinks make you feel better? _____
_____
Do any foods/drinks make you feel worse? _____
_____
On average, how many times do you chew your food? _____
What else do you do while your are eating? (TV, driving, reading, phone, etc)_____
What do you drink with meals? _____
When you drink water, does it tend to go through you quickly or stay in for a while? _____
Do you brush and floss? _____ Do you have periodontal disease? _____

Have you ever had any food allergy or food sensitivity testing done? _____ Do you have any food intolerances: _____

If so, please describe these results and reactions: _____
_____
_____

Do you get routine physical exercise: _____ What type:_____
Do you use tobacco products: _____ How much: _____ Previously: _____ How long: _____
Do you use alcohol products: _____ How much: _____ Previously: _____ How long: _____
Do you use caffeine products (include energy products and herbs): _____ How much: _____
Do you drink carbonated beverages (sodas): _____How often and how much:_____
How often do you have a bowel movement? _____
Please elaborate as much as possible about your bowel habits (don't worry, I won't tell). It is important i.e. color, how hard, horribly stinky or just smelly
_____
_____

FAMILY HISTORY

Do you have parents or siblings (living or dead) who have had (Circle yes or no):
High Homocysteine Blood Levels: Yes No
Cancer: Yes No If yes, please list what type: _____
Diabetes or Insulin Resistance: Yes No If yes, was the Diabetes Type 1 or Type 2 (circle)
Celiac Disease: Yes No
Multiple Sclerosis Yes No
Lupus Yes No

What are Your most significant stressors?

_____
_____
_____
_____
_____

How easily and fast are you to react and get angry, anxious, sad, irritable? Describe. How long does it take to calm down on average? Minutes? Hours? Days?

_____
_____
_____
_____
_____

What Do you Do For Fun and to Reduce Stress?

_____
_____
_____
_____
_____

SYMPTOM CHART (All Patients)

Use the following chart to rate your symptoms on a 1-5 scale.(1 being not at all, 5 being severe, do not rate if not applicable)

	1	2	3	4	5
Aches and Pains					
Acne					
Aggressive Behavior					
Aging rapid					
Allergies					
High Blood pressure					
Low blood pressure					
Low Blood sugar					
Cold Body Temperature					
Bone Loss					
Chemical Sensitivity (allergies to many chemicals)					
High Cholesterol					
Constipation					
Depressed					
Fatigue in the Evening					
Fatigue all day long					
Fatigue in the Morning					
Fibrocystic Breasts					
Fibromyalgia					
Goiter					
Hair dry or brittle					
Hair- scalp loss					
Body or scalp hair growth increased					
Headaches					
Hearing loss					
Heart Palpitations					
Hoarseness					
Hot Flashes					
Incontinence					
Infertility Problems					
Irritable					
Libido Decreased					
Memory Lapse					
Menstrual Cycles Regular					
Morning Hunger					
Heavy Menstrual Bleeding					
Heavy Menstrual Cramping					
Change in menstrual cycle					
Mood Swings					
Decreased Muscle Size					
Nails breaking or brittle					
Nervous					
Night Sweats					
Numbness-hands and feet					
Pulse rapid					
Pulse slow					
Thinning Skin					
Trouble getting to sleep					
Trouble staying to sleep					

Not getting enough sleep					
Yawn excessively					
Stamina Decreased					
Snoring?					
Vivid dreams/Nightmares?					
Stress					
Sugar Cravings					
Decreased Sweating					
Swelling Puffy Eyes/Face					
Tearful					
Tender Breasts					
Triglycerides Elevated					
Urinary urge increased					
Uterine Fibroid					
Vaginal Dryness					
Frequent yeast infections					
Water Retention					
Weight Gain in the Hips					
Weight Gain in the Waist					
Rectal itching					
Cankers					
Cold Sores					
Belching					
Sulfur belching					
Bloating/Gas					
Diarrhea					
Abdominal Pain					
Oily Food causes symptoms? (Nuts, olive oil, bacon)					
Ringing in the Ears					
Anxiousness					
High Energy					
Foggy thinking					
Difficulty focusing					
Impulsive					
Inflammation (joints or muscle aches are one indicator)					
Lack of Motivation					
Difficulty feeling pleasure					
Mind Racing					
Appetite					

GYNECOLOGICAL HISTORY (women only)

Age at first period: _____ Date of last period: _____
Date of last pelvic exam: _____ and Pap smear: _____ Mammogram: _____
Results: _____
Have you ever had an abnormal pap? _____ Treatment: _____
Are you sexually active: _____Are you trying to get pregnant: _____
Current birth control method: _____ How long: _____
Problem with it: _____ How long: _____
Past birth control and any related problems: _____
Rate your cramping associated with your period (1-10): _____
Describe any Premenstrual symptoms along with when the start and end:
_____
_____
_____
Any current changes in your normal cycle: _____
Any pelvic pain, pressure or fullness: _____ Describe: _____
_____
Any unusual vaginal discharge or itching: _____Describe: _____
_____
Age at first pregnancy: _____
How many full-term pregnancies: _____
Were there any problems with these pregnancies: _____
_____
Any interrupted pregnancies (miscarriages or abortions) :
_____
Have you had a tubal ligation: _____When: _____
Have you had any part or whole ovary removed: _____When_____
Have you had a hysterectomy: _____When: _____
Do your ovaries remain: _____

Fill out the following chart for period severity and length. Day 1 is the first day of your period.

Severity	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Changing pad/tampon every hour																
Changing pad/tampon every 2-4 hours																
Changing pad/tampon every 4-8 hours																
Changing pad/tampon more than 8 hours																
Spotting																
Cramping? yes or no Put an S if severe PMS Symptoms																

Severity	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Changing pad/tampon every hour														
Changing pad/tampon every 2-4 hours														
Changing pad/tampon every 4-8 hours														
Changing pad/tampon more than 8 hours														
Spotting														
Cramping? yes or no PMS Symptoms														

1066 N Yellowstone Hwy
Rexburg, ID 83440
(208) 390-6236 Fax (208) 906-8679

AUTHORIZATION to OBTAIN PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Last First MI

Address:_____

_____
City State Zip Code

Birth Date _____/_____/_____ **Telephone #**: _____

I hereby authorize

_____
Name of Facility

_____
City State Zip Code

to release my protected health information to Teton Sage

Attention: Amy McDougal, PharmD.
Fax Number: 208-906-8679
1066 N Yellowstone Hwy
Rexburg, ID 83440

PURPOSE OF DISCLOSURE: Consultation

INFORMATION TO BE RELEASED (Please be specific and enter date of service if known):

☐ Entire medical record_____, excluding _____
☐ Pathology Reports _____
☐ Laboratory Reports _____
☐ MRI Reports _____
☐ Medication Records_____
☐Other (specify content)_____

I understand that I may cancel this authorization in writing at any time, except to the extent that the above healthcare provider has already sent the information to Teton Sage. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Teton Sage will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. *I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations; however the recipient may be prohibited from disclosing substance abuse information.*

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire **six months** from the date of the signature listed below. I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

Signature of Patient_____**Date**_____

(Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal representative is required for patients under the age 18 without emancipated status or a special condition.)

Signature of Legal Representative_____
Relationship to Patient_____Date_____

Please make a copy of this release for your record

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(208) 390-6236 Fax (208) 906-8679

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit Teton Sage or a Teton Sage provider for health care, an electronic and paper record of your visit is made. This record usually contains identification and financial information and information such as, symptoms, diagnoses, test results, a description of the physical examination, and a treatment plan. This record of information is often referred to as your "medical record," or "health information." It is used:

- To plan for your care and treatment;
- To communicate information among your health care professionals;
- To legally record the care you received;
- To verify to you what services were actually provided;
- To help Teton Sage and all providers approved to practice at Teton Sage evaluate and improve the care they provide and the outcomes they achieve;
- To provide a source of information for important health related research;
- To educate health professionals and students; and
- To provide a source of information for facility planning and marketing.

Teton Sage has always worked to protect your personal health information and will continue to do so. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIP AA) now requires Teton Sage to provide you with this notice describing our legal duties and privacy practices concerning your personal health information. In general, when we use or disclose your health information, we are obligated to use or disclose only the least amount of information necessary to achieve the purpose. The least necessary rule does not apply if the disclosure is to your health care provider regarding your treatment, to you, or due to a legal requirement. It is for your benefit as a patient that we are required to abide by the privacy practices described in this notice.

All of the below listed organizations and individuals agree to abide by the terms of this notice. They will share your health care information with each other as necessary for your treatment, to get paid for services, and to carry out other activities such as quality assessment and improvement activities.

This joint notice describes how Teton Sage employees and providers use and share your health information. Teton Sage reserves the right to change the privacy practices described in this notice, in keeping with the law. Changes to our privacy practices would apply to all health information maintained by us. If we change our privacy practices, you may read a summary of substantive changes on our website at www.tetonsage.com. You may obtain a revised copy of the privacy notice at our facility. We are able to use your health information without your written authorization for the following purposes:

Treatment. We may use medical information about you to provide medical treatment or services. We may disclose medical information about you to providers or other personnel who are involved in your care or treatment.

Teton Sage will also use your health information for teaching purposes, administrative activities, or licensing purposes. To remind you of your appointments for visits, we may use your health information. For example, we will view your medical record to determine the date and time of your next appointment with us, and then send you a reminder letter or call you to remind you of the appointment. We will want to let you know of other treatments or services we offer that may improve or benefit your health. We may communicate to you about good health practices, such as a mailing with information about how to lower cholesterol, about health fairs, wellness classes or support groups we offer.

Other special instances when we can use your health information without your written authorization.

I. As required or permitted by law. In certain circumstances, we may have to report some or your health information to legal entities, such as court officials.

11. To those involved with your care or payment for your care. If people such as family members, relatives, or close personal friends are helping care for you or helping you pay your medical bills, you determine if we may disclose relevant health information about you to those people. You have the right to object to such disclosure, unless you are incapacitated or there is an emergency. When Teton Sage is required to obtain your authorization to use or disclose your health information:

Except for the situations previously listed, any other use or disclosure of your health information requires us to obtain your specific written authorization. For example, if we wanted to make a patient education video and have you participate in the film, we would need your authorization.

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Teton Sage Privacy Officer at (l)208-390-6236. Specifically, you have the right:

1. To inspect and copy your health information. You have the right to inspect and obtain a copy of your health information. In addition, we may charge you a reasonable fee if you want a copy of your health information.
2. To request an amendment of your health information. If you believe your health information is incorrect, you may ask us to amend the information. You will be asked to make such a request in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.
3. To request restrictions on certain uses and disclosures. You have the right to notify us that you want restrictions placed on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment, our payment, or our health care operation activities. You may want to restrict the health information provided to family or friends involved in your care or payment of medical bills, or to restrict the health information provided to authorities involved with disaster relief efforts. However, Teton Sage is not legally required to agree to such restrictions. While we will consider your request, because of the number, complexity, and nature of the services we deliver we may not be able to grant the request.
4. To, receive confidential communication of health information. You have the right to request alternative means or locations where we may communicate your health information to you. For example, you may wish to receive a follow up call from your provider at your work telephone number instead of your home number. Or you may wish to have your billing information sent to a private address. We will accommodate reasonable requests.
5. To receive a report listing to whom we have disclosed your health information. In some limited instances, you have the right to request a report of the disclosures of your health information we have made during the previous six years. This written report must include the date of each disclosure, who received the disclosed health information, a brief description of the disclosed health information, and why the disclosure was made. We must comply with your request for the report within 60 days, unless you agree to a 30-day extension. We may not charge you for the report, unless you request such a report more than once per year. Our report will not include disclosures made to you, disclosures where you signed the authorization form, or disclosures for purposes of treatment, payment, or health care operations, information that is part of a limited data set, our directory, national security, law enforcement! corrections, and certain health oversight activities.
6. To obtain a paper copy of this notice. Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically. This notice is available on-line at www.tetonsage.com. Or you may call the Privacy Officer at (208)390-6236. to request a paper copy of this notice.
7. To file a complaint. If you believe your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. Complaints in no way affect how we care for you. To file a complaint with either Teton Sage or the Department of Health and Human Services, please contact the Teton Sage Grievance Coordinator at (208)390-6236 who will provide you with the necessary assistance and paperwork.

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Teton Sage Privacy Officer at (208)390-6236.

Revised 5/2/2012