Apex Lifestyle Medicine

Circle Location: **Canton, OH** **Cleveland, OH**

Client Name_____ Date: _____ ☐ Male ☐Female

Email: _____ SS #/SIN_____ DOB_____

Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home phone_____ Cell Phone _____

Client's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Signature Date

Please print name and relationship for each person to whom you are authorizing released of your private health care information and account balances

NAME	Relationship
_____	_____
_____	_____
_____	_____

_____ _____

Signature of the Patient, Parent or Guardian Date

Health History

Client Name: _____DOB: _____Date:_____

Main reason you are looking to lose weight: _____

_____

How much weight are you trying to lose:_____

_____

Have you tried anything else to lose weight with success?_____

_____

Have you tried any other weight loss program without success?_____

_____

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles…… NO YES	Anemia……..NO YES	Back Trouble……....NO YES	Hepatitis…….NO YES
Mumps……. NO YES	Bladder Infection……....NO YES	High Blood Pressure…….NO YES	Ulcer……...NO YES
Chicken Pox…… NO YES	Epilepsy…….....NO YES	Low Blood Pressure……...NO YES	Kidney Disease……..NO YES
Whooping Cough…. NO YES	Migraine Headaches. .....NO YES	Hemorrhoids……..NO YES	Thyroid Disease……NO YES
Scarlet Fever…… . NO YES	Tuberculosis……NO YES	Date of Last Chest X-Ray_____	Bleeding Tendency……NO YES
Diphtheria…… NO YES	Diabetes……NO YES	Asthma……NO YES	Any Other Disease…….NO YES
Small pox……NO YES	Cancer……...NO YES	Hives of Eczema……...NO YES	(Please List):
Pneumonia……. NO YES	Polio…… NO YES	AIDS & HIV…… NO YES	
Rheumatic Fever…... NO YES	Glaucoma……..……NO YES	Infectious Mono…….. NO YES	_____
Arthritis…… NO YES	Hernia……NO YES	Bronchitis…… NO YES	
Venereal Disease….. NO YES	Blood or Plasma Transfusion……..NO YES	Mitral Valve Prolepses……...NO YES Stroke……NO YES	_____

Previous Hospitalizations/Surgeries/Serious Illnesses

	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			
Excessive Exposure At home or at work to:	Fumes: _____	Dust: _____	Solvents: _____	Airborne Particles: _____	Noise: _____

CLINICIAN SIGNATURE: _____ DATE REVIEWED:_____

CLIENT NAME: _____ _____ DATE:_____

Name:_____ DOB _____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

List your Health Goals in order of importance:

1. _____
2. _____
3. _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Client, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

PATIENT CONSENT FOR COMMUNCATION

We have the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Clients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience with in our office, and to provide general health reminders/information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Apex Lifestyle Medicine. _____ (initial)
2. I consent to receive text messages from Apex Lifestyle Medicine at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is: _____ Carrier:_____ _____ (initial)
3. I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is:_____ _____ (initial)

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. ____ (Initial)

Signature: _____ Date:_____

Authorization to Release Records to my Family Physician or Specialist

I _____ authorize James Franz, DO to release my records from Apex Lifestyle Medicine to _____, my Family Physician as well as to _____, the Specialist that I have seen for my condition (if applicable).

Name:_____ Signature: _____

Authorization for Release of Medical Information

I _____request and authorize_____ to release _____ records to help them in determining my care.

Please Fax Records ATTN to: Apex Lifestyle Medicine

Fax Number: (330) 479-9165

Patient Signature: _____ Date of Birth: _____

Social Security Number: _____

Dr. Jim Franz, DO
Apex Lifestyle Medicine
Fax (330) 479-9165

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Apex Lifestyle Medicine and its providers as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____
(patient signature)

X_____(SEAL) X_____
(Guardian if applicable) (Printed Name of Patient)

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Provider" refers to Dr. James Franz, DO or Apex Lifestyle Medicine.

I consent to the use or disclosure of my protected health information by the Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Provider. I understand that analysis, diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Providers not required to agree to the restrictions that I may request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider.

I have the right to revoke this consent, in writing, at any time, except that the Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider. The Notice of Privacy Practices for the Provider is also posted in the waiting room at Apex Lifestyle Medicine. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

The Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name:_____ Signture:_____