CONSIGLIO
WELLNESS CENTER

Patient Medical History

Patient Name: _____ **DOB:** _____

Medication Allergies: _____

Environmental/Other Allergies: _____

Primary Care Physician: _____

Gender: _____

Pregnant: Yes ☐ No ☐ Breastfeeding: Yes ☐ No ☐ Last Menstrual Period: _____

Current Medications (prescription, over-the-counter, vitamins, supplements)

Medication	Dose/Strength	Medication	Dose/Strength

Past Medical History (make an X next to conditions you currently have or have had in the past)

Condition	Current	Past	Condition	Current	Past
Heart Disease			High Blood Pressure		
High Cholesterol			Liver Disease		
Cancer _____			Anemia/Blood Disorder		
Diabetes			Thyroid Disease		
Stroke			Seizures		
Headaches/Migraine			TB (Tuberculosis)		
Mental Health Disorder (Anxiety/Depression/Bipolar)			Nerve Impairment		
Spinal Disorder			Sleep Apnea		
Lung Disease (Asthma/COPD)			Chronic Skin Condition		
GI Disorder (Reflux/Heartburn)			Kidney/Bladder Prostate		
Other Conditions:					

Surgical History

Surgery	Approximate Date

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Patient Name: _____ DOB: _____

Family History

Condition	Mother	Father	Sister	Brother	Daughter	Son	Grand-mother	Grand-father
Heart Disease								
High Cholesterol								
Cancer_____								
Diabetes								
Stroke								
Headaches/Migraine								
Mental Health Disorder (Anxiety/Depression/Bipolar)								
Spinal Disorder								
Lung Disease (Asthma/COPD)								
GI Disorder (Reflux/Heartburn)								
High Blood Pressure								
Liver Disease								
Anemia/Blood Disorder								
Thyroid Disease								
Seizures								
TB (Tuberculosis)								
Nerve Impairment								
Sleep Apnea								
Chronic Skin Condition								
Kidney/Bladder Prostate								
Deceased/Age at Death								
Other Conditions:								

Social History

Do you:	Current	Past	Never
Smoke Cigarettes			
Chew Tobacco			
Smoke Marijuana			
Use Vaping Device			
Drink Alcoholic Beverages			
Drink Caffeine			

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Patient Demographics

Name: _____ Birthdate: _____

Address: _____ Apartment: _____ City: _____

State: _____ Zip: _____ Home/Cell: _____

Home e-mail: _____ Other e-mail: _____

Preferred Pharmacy: _____

Pharmacy Address: _____

EMERGENCY CONTACT

Contact name: _____ Relationship: _____

Home/Cell: _____

EMPLOYMENT INFORMATION FOR DISTRICT EMPLOYEE

Employer: _____ Employee phone: _____ Ext: _____

Occupation: _____

Relationship to Employee _____

Work e-mail: _____

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Acknowledgement of Receipt of The Privacy Practices/HIPAA

The privacy practice is/was provided so that I can make an informed decision whether to allow release of the information.

I understand that I do not have to sign this authorization in order to receive treatment from Consiglio Wellness Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Consiglio Wellness Center

1501 NW Jefferson St

Blue Springs, MO 64015-7242

Signed by: _____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**

_____ _____

Print Patient's Name **Date**

_____

Print Name of Patient's Legal Guardian (if applicable)

I authorize the staff at Consiglio Wellness Center to release health information to the following individual(s) or medical practice(s):

_____

Name Relationship

_____

Medical Practice Name/Provider Name Fax Number