How did you hear about us?

Date_____ _____

Personal Information-Provide a Driver's License/State ID/and complete information below:

First Name:_____ Last Name:_____

Street address:_____

City:_____ State:_____ Zip Code:_____

Date of birth:_____ SSN:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Primary Insurance-Provide insurance card and complete the information below:

Carrier:_____

Subscriber's ID/Policy Number:_____

Subscriber's Name (as it appears on card):_____

Relationship to Subscriber:_____

Subscriber's Date of Birth:_____

Secondary Insurance:

Carrier:_____

Subscriber's ID/Policy Number:_____

Subscriber's Name (as it appears on card):_____

Relationship to Subscriber:_____

Subscriber's Date of Birth:_____

I authorize treatment of the person name above and agree to pay all fees and charges for such treatment.

In signing this you agree that all insurance payments are assigned to the medical practice.

Signature:_____ Date:_____

Emergency Contact Information:

Name:_____ Phone Number:_____

Relationship:_____

I give Abundant Wellness MD permission to call my Emergency Contact to request that I contact the medical practice if they are unable to reach me.

Signature:_____ Date:_____

Primary Care
Medical History Form

Date:_____ Age:_____ Date of Birth:_____

Laste Name:_____ First Name:_____

Pharmacy:_____

List prescribed and over the counter medications, including vitamins and/or supplements.

Medication	Dosage	How Often	Reason

List all medication allergies you have.

Circle if: No Allergies

Allergy	Mild/Mod/Severe	Reaction

List all surgeries you have had. Circle if: No Surgery

Type	Location (Hospital)	Surgeon

General Medical History

Do you currently or have you previously been TREATED for any of the following:

	Yes	No		Yes	No
Asthma			Kidney Infection-recurrent		
Allergies (seasonal)			Kidney Stones		
Allergies (food)			Liver Disease		
Bronchitis-recurrent			Prostate Problems		
Cancer-Type			Skin Disorders		
Depression/Anxiety			Sleep Apnea		
Diabetes-Type 1 or 2			Stomach Ulcer		
Diabetes Gestational			Thyroid Problems		
Emphysema			Stroke/TIA's		
Fast/Irregular Heartbeat			Other Bowel Problems		
Heart Murmur			Other Lung Problems		
Heart Attack			Other heart Problems		
Hepatitis			Other Kidney/Urinary		
High Blood Pressure			Other Abnormal Heart Beat		
High Cholesterol			Do you wear Glasses/Contacts		
Heart Disease			Do you wear a hearing device		

Check any of the following that you have been tested for:

Test	Normal	Abnormal	Year		Yes	No	Year
Eye Exam				Tetanus (see next line)			
Cholesterol				With Pertussis (Tdap)			
Heart Testing				Pneumonia Vaccine			
Treadmill Stress Test				Shingles Shot			
Echo Cardiogram				Flu Shot			
EKG				Women's Health			
Colonoscopy				Birth Control			
Osteoporosis (Dexa)				Date of last period			
Prostate (PSA)				Are they regular?			
Prostate Exam				Birth History			
Last Full Physical				Total # of Pregnancies			
PAP Test				Total # of Miscarriages			
Mammogram				Total # of Living Children			

Additional Medical Information:

Social History:

	Type/How Often? (X times/week) (packs/day) Number of Years
Do you Exercise regularly?	
How often do you drink alcohol?	
Any history of Alcohol abuse?	
Do you smoke?	If History of smoking, date quit.
Other forms of Tobacco?	
How much Caffeine do you drink? (soda, energy drinks, etc?	
Do you currently use, or have in the past, used drugs?	
Marijuana	
Cocaine	
Meth	
Opiates or Amphetamines	
Other	

	Yes	No
Do you have increased risk factors for an HIV Infection?		
Have you ever been exposed to Tuberculosis?		
Have you had excessive exposure to the Sun/UV light due to work or recreation?		
List any additional environmental risks you may be exposed to regularly at home or work.		

Marital Status (please circle): Married Single Divorced Widow
Who lives in your household?_____
How many children do you have?_____
Would you consider your home a stable environment?_____
If no, please explain._____

List family members (first degree relative or grandparent) who have had any of the following conditions.

	Relationship		Relationship		Relationship
Anemia		Epilepsy		High Cholesterol	
Asthma		Glaucoma		Kidney Disease	
Obesity		Leukemia		Thyroid Disease	
Cancer		Psychiatric		Hypertension	
Diabetes		Heart Disease		Substance Abuse	
Stroke		Lung Disease		Bleeding	

	Living	Deceased	Date	Cause of Death	
Mother					
Father					
Sibling #1					

Sibling #2					

Work/Education History

Occupation:	Time in current position:
Employer:	
Highest level of education completed (circle). Gradutate Undergraduate Associates High School GRE	
Hobbies:	Interest:
Prior Military Service:_____ Branch/Rank:_____If so when discharged?_____	

Spirituality

	Yes	No
Is spirituality or religion a significant part of your life?		
Do you participate in a spiritual community?		
Would you like your spiritual community involved in your treatment?		
What region or denomination do you indentify with?		
What gives your life meaning?		
How can your beliefs, values, or practices help you overcome the problems that we are addressing?		

Review of Symptoms

Please circle any of the following symptoms that you have experienced in the last month:

General	Fever Chills Weight Changes Night Sweats Fatigue
Skin	Rashes Lumps Sores Itching Dryness Changers in Nail/Hair
Head	Headache Head Injury
Eyes	Change in vision Pain Redness Watering Double Vision
Ears	Change in hearing Pain Discharge Ringing Vertigo
Nose/Sinuses	Frequent Colds Congestion Hay Fever Nose Bleed Sinus Trouble
Mouth/Throat	Bleeding Gums Sore Throat Hoarness Sore Tongue
Neck	Lumps Swollen Glands Pain Stiffness Thyroid Problems
Breasts	Lumps Discharge Pain Skin Changes Nipple Changes
Lungs	Cough Sputum Shortness of Breath Coughing up Blood Snoring
Heart	Chest Pain Palpitations Shortness of Breath Swelling
Bowels	Diarrhea Constipation Bleeding Heart Butn Difficulty Swallowing Jaundice Change in Bowel habits Discolored Stool Abdominal Pain Incontinence
Bladder	Visible Blood Burning Change in Urinary Habits Difficulty Urinating Incontinence Urgency Frequency Getting up Night to Urinate Kidney Stones
Reproductive	Sores or Ulcers Discharge Bleeding Sexual Problems

Blood Vessels	Leg Cramps Swelling Blood Clots
Musculoskeletal	Arthritis Deformity Weakness Muscle Pain or Cramps Back Pain
Neurologic	Headaches Seizures Numbness/Tingling Paralysis Tremors Memory
Blood	Anemia Bleeding Bruising
Glands	Intolerance to Heat or Cold Change in Appetite Excessive Thirst/Hunger Excessive Fatigue
Psychiatric	Nervousness Depression Insomnia Anxiety

Additional Notes

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns	[redacted]	+ [redacted]	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: [redacted]

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: Gender: Date:

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

- ☐ Never (0 point)
- ☐ Monthly or less (1 point)
- ☐ 2 to 4 times a month (2 points)
- ☐ 2 to 3 times a week (3 points)
- ☐ 4 or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks (0 point)
- ☐ 3 or 4 drinks (1 point)
- ☐ 5 or 6 drinks (2 points)
- ☐ 7 to 9 drinks (3 points)
- ☐ 10 or more drinks (4 points)

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never (0 point)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

Points

Abundant Wellness MD
8787 N Owasso Expressway St J
Owasso, OK 74055
Ph: 918-516-2296 Fax: 918-516-2801

Name: _____ Date: _____

Are you a:

- ☐ Current smoker
- ☐ Former smoker

How many years smoked: _____
How many years ago quit _____

- ☐ Amount smoked — Cig per Day _____
- ☐ Non-smoker
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Uses tobacco in other forms

Additional Findings: Tobacco User

- ☐ Chews fine cut tobacco
- ☐ Chews leaf tobacco
- ☐ Chews plug tobacco — Cans per Day _____
- ☐ Chews twist tobacco
- ☐ Heavy cigarette smoker (20-39 cigs/day)
- ☐ Light cigarette smoker (1-9 cigs per day)
- ☐ Moderate cigarette smoker (10-19 cigs/day)
- ☐ Pipe smoker
- ☐ Rolls own cigarettes
- ☐ Snuff user
- ☐ Trivial cigarette smoker (less than one cig/day)
- ☐ Very heavy cigarett smoker (40+ cigs/day)

Additional Findings: Tobacco Non- User

- ☐ Ex-pipe smoker
- ☐ Ex-Trivial cigarette smoker (<1/day)
- ☐ Ex-very heavy cigarette smoker (40+/day)
- ☐ Never chewed tobacco
- ☐ Ex-tobacco chewer

Dr. Loretta Farrell
8787 N. Owasso Expressway, Ste J
Owasso, OK 74055
(918)-516-2296

Our Policy on No Show Appointments:

Missed appointments (no show) affect our ability to provide timely attention to our patients. When a patient does not show up for their appointment , another patients loses the opportunity to be seen. After 3 no show appointments, the account will be reviewed and the possibility of the patient being dismissed from the office could occur.

We would like to reschedule your appointment and ask that you call our office to reschedule at your earliest convenience.

_____ _____

Patient Name Date

Abundant Wellness MD

Consent To Text, For Patient Portal, And Medication History Authority

I understand that I give permission for Abundant Wellness MD to text me for future appointments and reminders. I also give permission to be invited to the Patient Portal provided by Abundant Wellness MD to receive access to my medical records.

I also give Abundant Wellness MD permission to download my Patient medication history automatically from my pharmacy benefit managers. (PBMs).

_____

Signature of Patient/Legal Guardian

_____

DOB

_____

Patient Name-Please Print

_____

Date

Abundant Wellness MD

Please note the following Payment Policy:

It is the policy of Abundant Wellness MD that payment is due at the time of service unless other financial arrangements are made in advance. We required all patients to pay their deductible, copay, and/or coinsurance at the beginning of every visit.

If you are covered by Health Insurance benefits, we will be happy to bill your insurance company. Please provide your insurance information to the front office staff. Accepting your insurance does not place all financial responsibilities on Abundant Wellness MD and you will be responsible for any unpaid balances by your plan.

As a courtesy, Abundant Wellness MD verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will be processed according to your plan and the patient will be responsible for any remaining balance the insurance does not pay.

We highly recommend you also contact your insurance company and check your covered benefits.

_____

Signature of Patient/Legal Guardian

_____

DOB

_____ Date:_____

Patient Name-Please Print

General Consent and Authorization for use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

I hearby give my consent for Abundant Wellness MD to use and disclose protected health information (PHI) regarding me to carry out treatment, payment, and healthcare operations (TPO).

I have received and reviewed the Notice of Privacy Practice (NOPP) prior to signing this consent. Abundant Wellness MD reserves the right ti revise its NOPP at anytime. A revised NOPP may be obtained by forwarding a written request.

With this consent Abundant Wellness MD may mail to my home or other alternative location to include my emergency contact any items that assist the medical practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent Abundant Wellness MD may email to my home or other alternative location to include my emergency contact any items that assist the medical practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Abundant Wellness MD restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Abundant Wellness MD to use and disclose my PHI to carry out my TPO. I may revoke consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior request. If I don't sign this consent, or later revoke it, Abundant Wellness MD may decline to provide treatment to me.

Patient Signature:_____ Date:_____