KIDSPACE

Adaptive Play and Wellness

www.kidspaceadaptiveplay.com

469 Buckland Road
South Windsor, CT
06074
phone (860) 432-9923
fax (860) 432-7553

Miela Gruber–Cooley ND— Registration Form

(Please Print)

Today's Date:_____ PCP:_____

Patient Information

Patient Name: (Last, First, Middle) _____

Is this your legal name: Yes__ No__ If not, what is your legal name:_____

Marital Status: ___Single: ___Married: ___Divorced: ___Separated: ___Widowed: ____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____

E-mail address:_____

Date of Birth:___/_____/____ Male___ Female___

Street Address:_____ P.O. Box_____

City:_____ State:_____ Zip Code:_____

Occupation:_____

Employer name & Phone:_____

Chose Dr. Gruber because/ Referred by: _____

_____

In Case of Emergency

Name of local friend or relative (not living at same address):_____

Relationship to patient:_____ Home Phone: (_____)_____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kidspace or insurance company to release any information required to process my claims.

Patient signature:_____ Date:_____

AUTHORIZATION FOR SHARING OF MEDICAL AND EDUCATIONAL RECORDS AND/OR PERMISSION TO DISCUSS MEDICAL HISTORY/RECORDS

PATIENT'S NAME: _____

CONSENT TO SHARE MEDICAL AND EDUCATIONAL RECORDS AND/OR DISCUSS MEDICAL HISTORY

I consent to the sharing of my medical and educational records with:
NAME: Practitioners at Kidspace Facility
ADDRESS: 479 Buckland Road, South Windsor, CT 06074
PHONE: (860) 432-9923

Patient Signature: _____Date: _____

Relationship to Patient, if signed by someone other than Patient: _____

Adult Intake Form

Date of first Visit: _____

Name: _____

Address:_____ City: _____ State: _____ Zip: _____

Telephone Number:

Home: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

Age: _____ Date of Birth: _____ Male: ___ Female: ____

Education: _____

Married: ___Separated: ___ Divorced: ___Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse: ___ Partner: ___ Parents: ___Children: ___Friends: ___ Alone: ___

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____

Work address:_____

Emergency Contact: _____ Relationship: _____

Phone number: (_____)_____-_____

HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

Are you Currently receiving healthcare? _____

If yes, where and from whom?_____

What are your most important health problems? List as many as you can in order of importance:

1.

2.

3.

4.

5.

Do you have any known contagious diseases at this time? _____

If yes, what?

FAMILY HISTORY

	Mother	Father	Brothers	Sisters	Maternal/Paternal Grandparents	Uncles/ Aunts
Age (if living)						
Health (good/poor)						
(Check if applicable)						
Cancer						
Diabetes						
Heart Disease						
High Blood pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Does your spouse or child have a history of any of the above? Please indicate:

_____

For all the following sections please indicate:
Y*=a condition you have now* ***N****= never had* ***P****=a condition you have had before*

Childhood Illnesses

Scarlet fever Y N P Diptheria Y N P Rheumatic fever Y N P
Mumps Y N P Measles Y N P German Measles Y N P

Hospitalizations and Surgery

What hospitalizations or surgeries have you had?

X-rays, CAT scans, or other studies have you had?

Electrocardiogram Y N Electroencephalogram Y N

Immunizations

Polio Y N Pertussis Y N
Tetanus shot Y N Diphtheria Y N
Measles Mumps Rubella Y N Other : _____

Allergies

Are you hypersensitive or allergic to…
Any drugs? _____
Any food? _____
Any environmentals?_____

Current Medications
Do you take or use?

Laxatives?	Y N	Pain relievers?	Y N	Antacids ?	Y N
Cortisone?	Y N	Appetite suppressants?	Y N	Antibiotics?	Y N
Tranquilizers?	Y N	Thyroid Medication?	Y N	Sleeping pills?	Y N

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:
1. _____ 4. _____
2._____ 5. _____
3. _____ 6. _____

Typical Food Intake

Breakfast:
_____
Lunch:
_____
Dinner:
_____
Snacks:
_____
To Drink:
_____

Habits
Main interests and Hobbies? _____
Do you exercise? Y N If yes, what kind? _____ How often/ _____
Watch Television Y N How many hrs?_____
Read? Y N How many hrs? _____

Average 6-8 hrs of sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have supportive relationship?	Y N	History of abuse?	Y N
Any major traumas?	Y P N	Use recreational drugs?	Y P N
Been treated for drug dependence?	Y P N	Treated for Alcoholism?	Y P N
Do you eat three meals/day?	Y N	Do you drink coffee?	Y P N
Use alcoholic beverages?	Y P N	Do you use tobacco?	Y P N

Smoked previously? Y N How many years? _____ Packs per day? _____

Do you eat out often?	Y N	Do you go on diets often?	Y N
Do you drink black or green tea?	Y P N	Do you drink cola or other sodas?	Y P N

How does your condition affect you? _____

What do you think is happening? _____

Why? _____

What do you feel needs to happen for you to get better? _____

_____

What do you enjoy most in your life? _____

How much change are you willing to make at this time for improving your health?

MINIMAL SOME COMPLETE

Is there any information about your health you would like to add?

General

Weight _____lbs Weight 1 yr ago _____lbs

Maximum weight _____lbs When?

Height?

When during the day, is your energy the best?_____Worst?_____

For all the following sections please indicate:
***Y**= a condition you have now* ***P**= a condition you have had before* ***N**= never had*

Mental/Emotional

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood swings?	Y P N	Tension?	Y P N
Anxiety or nervousness?	Y P N	Memory Problems?	Y P N
Considered/Attempted suicide?	Y P N	Poor concentration?	Y P N

Endocrine

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

Immune

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

Neurologic

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N

Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

Skin

Rashes?	Y P N	Eczema, hives?	Y P N
Acne, boils?	Y P N	Itching?	Y P N
Color change?	Y P N	Perpetual hair loss?	Y P N
Lumps?	Y P N	Night sweats?	Y P N

Head

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ injury?	Y P N

Eyes

Spots in eyes?	Y P N	Cataracts?	Y P N
Impaired visions?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/Strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double vision?	Y P N	Glaucoma?	Y P N

Ears

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

Nose and Sinuses

Frequent colds?	Y P N	Nose bleeds?	Y P N
Stuffiness?	Y P N	Hay fever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

Mouth and Throat

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

Neck

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

Respiratory

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing?	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of Breath?(SOB)	Y P N
Tuberculosis?	Y P N	SOB lying down?	Y P N
		SOB at night?	Y P N

Cardiovascular

Heart disease?	Y P N	Angina?	Y P N
High/Low blood pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest Pain?	Y P N
Swelling in ankles?	Y P N		

Gastrointestinal

Trouble Swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements: How often? _____	
Blood in stool?	Y P N	Is this a change? Y N	
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice? (yellow skin)	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

Urinary

Pain on urination?	Y P N	Increased Frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

Male Reproduction

Hernias?	Y P N	Testicular Masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal Disease?	Y P N	Discharge or sores?	Y P N

Are you sexually active? Y N | Chlamydia? Y P N

Gonorrhea? Y P N | Condyloma? Y P N

Impotence? Y P N | Premature ejaculation? Y P N

Herpes? Y P N | Syphilis? Y P N

Birth control? _____ Type? _____

Female Reproduction

Age of first menses? _____ Age of last menses? _____

Are cycles regular? Y N Length of cycle? _____days. Duration of menses? _____days.

Bleeding between cycles? Y P N | Painful menses? Y P N

Heavy or excessive flow? Y P N | PMS? Y P N

PMS symptoms? _____ Pain during intercourse? Y P N

Clotting? Y P N | Discharge? Y P N

Birth control? Y P N | Birth control Type? _____

Number of pregnancies? _____ Number of live births? _____

Number of miscarriages? _____ Number of abortions? _____

Endometriosis? Y P N | Ovarian cysts? Y P N

Difficulty conceiving? Y P N | Cervical dysplasia? Y P N

Sexual difficulties? Y P N | Abnormal PAP? Y P N

Gonorrhea? Y P N | Chlamydia? Y P N

Condyloma? Y P N | Herpes? Y P N

Syphilis? Y P N | Are you sexually active? Y N

Menopausal symptoms? Y P N | Do breast self exams? Y P N

Breast lumps? Y P N | Breast pain/tenderness? Y P N

Nipple discharge? Y P N

Musculoskeletal

Joint pain or stiffness Y P N | Arthritis? Y P N

Broken bones? Y P N | Weakness? Y P N

Muscle spasms or cramps? Y P N | Sciatica? Y P N

Blood/Peripheral Vascular

Easy bleeding or bruising? Y P N | Anemia? Y P N

Deep leg pain? Y P N | Cold hands/feet? Y P N

Varicose veins? Y P N | Thrombophlebitis? Y P N

Welcome! I am glad to serve you! If you have any questions, please ask!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Dr. Miela Gruber's Office has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Miela Gruber, ND
(860) 432-9923

I also understand that I am entitled to receive updates upon request if Dr. Miela Gruber's Office amends or changes its Notice of Privacy Practices in a material way.

_____
Signature

_____
Relationship to Patient, if signed by someone other that patient

_____
Date

THIS SECTION IS TO BE COMPLETED BY DR. MIELA GRUBER'S OFFICE, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specify): _____

_____ _____
Name and title of employee *Date*

A photocopy of this agreement shall be considered as effective as the original.

Summary of Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to help you to obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures based on your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a notice of our privacy practices.

A copy of the complete Notice is available upon request.