



**PLENA**  
 Integrative Health Center  
 Compassionate Care for Mind, Body, & Soul

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 www.plena-ihc.com

**PATIENT REGISTRATION FORM**

**Legal Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_  
**Preferred Pronouns:** \_\_\_\_\_  Decline to answer **Preferred Name:** \_\_\_\_\_  
**Marital Status:**  Single  Married  Divorced  Separated  Widowed **SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Address:** \_\_\_\_\_  
 **Home:** \_\_\_\_\_  **Cell:** \_\_\_\_\_  **Work:** \_\_\_\_\_ (Check preferred)  
**Email:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Preferred Language:** \_\_\_\_\_

May we text/email/leave voice reminders and messages?  YES  NO  
 May we retrieve prescription history when needed?  YES  NO **Preferred Pharmacy:** \_\_\_\_\_

**Primary Insurance Company:**

**INSURANCE CO NAME** \_\_\_\_\_  
**POLICY #** \_\_\_\_\_ **GROUP #** \_\_\_\_\_  
**SUBSCRIBERS NAME** \_\_\_\_\_ **SUBSCRIBERS DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**SUBSCRIBERS SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **EFFECTIVE DATE OF COVERAGE** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**SUBSCRIBERS ADDRESS:** \_\_\_\_\_  
**SUBSCRIBERS EMPLOYER:** \_\_\_\_\_  
**SUBSCRIBER' RELATIONSHIP TO YOU:**  Self  Spouse  Parent  Other: \_\_\_\_\_

**Secondary Insurance Company:**

**INSURANCE CO NAME** \_\_\_\_\_  
**POLICY #** \_\_\_\_\_ **GROUP #** \_\_\_\_\_  
**SUBSCRIBERS NAME** \_\_\_\_\_ **SUBSCRIBERS DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**SUBSCRIBERS SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **EFFECTIVE DATE OF COVERAGE** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**SUBSCRIBERS ADDRESS:** \_\_\_\_\_  
**SUBSCRIBERS EMPLOYER:** \_\_\_\_\_  
**SUBSCRIBER' RELATIONSHIP TO YOU:**  Self  Spouse  Parent  Other: \_\_\_\_\_

**Responsible Party: (if someone other than patient)**

**Legal Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Address:** \_\_\_\_\_ **Apt #:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
**Relationship to patient:** \_\_\_\_\_

**Emergency Contact:**

**Name:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Address:** \_\_\_\_\_

**PATIENT/LEGAL GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Consent to Treat**

I \_\_\_\_\_ (*patient name*) give permission for Plena Integrative Health Center to give me medical treatment. I understand that I have the right to refuse any procedure or treatment. I understand that I have the right to discuss all medical treatments with my provider.  
\_\_\_\_\_  
(Initials)

I allow Plena Integrative Health Center, or their appointed billing service, to file insurance claims on my behalf for the care I receive. I understand that in doing so, Plena Integrative Health Center will have to send my medical information to my insurance company. I also understand my insurance benefits are a contract between myself and my insurance company and that I am responsible for the cost of my care if my insurance does not pay in full or that I do not have insurance. \_\_\_\_\_  
(Initials)

I give Plena Integrative Health Center, or their appointed billing service, permission to contact me via email at \_\_\_\_\_ or leave a message at \_\_\_\_\_. \_\_\_\_\_  
(Initials)

I also consent to receive text messages/leave voicemails at \_\_\_\_\_. \_\_\_\_\_  
(Initials)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Release of Information:**

Patient health is confidential and private. The patient or legal representative must give permission to include others in discussion about their health. These discussions include things such as health history, explanations about the treatment or tests to be done, results of treatments or tests, discharge care needs, etc. Confidential information or discussions will not be shared with others without the patient's authorization. Persons the patient allows to enter the examination room will have implied authorization for the above. If you wish to include specific people in discussion of your healthcare and allow them to contact Plena Integrative Health Center on your behalf, please list them below:

<b><u>Name:</u></b>	<b><u>Relationship:</u></b>	<b><u>Phone Number:</u></b>
1.		
2.		
3.		

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

I have reviewed this office’s Notice of Privacy Practices that explains how my protected health information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document and authorize the use and distribution as described.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA INFORMATION and CONSENT FORM**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, text message, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or healthcare provider.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Health History

Preferred Name	Preferred pronouns	Age:
Referred by	Primary Care Provider	
What brings you to our office today?		
Office Use Only		
Weight:	Height:	BP:
Pharmacy		

### Allergies (list medications, foods, latex)

Allergen	Reaction

### Your Current Medications (please include hormones, vitamins, supplements, non-prescription medications)

Name & Dose	How often?	For what reason?	Who prescribed it?

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Current Symptoms

Are you currently having ...			Describe
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Weight gain or loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Changes in Wart/Mole	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Rash	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Glasses/contact lenses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hearing loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Season allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Difficulty breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Breast mass or pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Chest pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Shortness of breath w/ exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Irregular Heart Beat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bloody stool	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Constipation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diarrhea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Painful urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Leaking urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Postmenopausal vaginal bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Vaginal odor/itching	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Vaginal dryness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Vaginal / Vulvar pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Abnormal vaginal discharge	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Pain with intercourse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Painful periods	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heavy periods	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Joint pain/swelling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Muscle pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
PMS symptoms	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Mood changes (anxiety, depression)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heat/Cold intolerance	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Easy Bruising	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Gynecological & Preventative Health History

Date last period started:
At what age did you start your first period?
How far apart are your periods?
How many days do you have your period?
Do you want to get pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, what are you using for birth control?
Have you had a sexually transmitted disease? Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever had a pap smear? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Results: _____
Any history of abnormal pap smears? Yes <input type="checkbox"/> No <input type="checkbox"/> Any treatment?
Have you had a mammogram? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Results: _____
Have you had a colonoscopy? Yes <input type="checkbox"/> No <input type="checkbox"/> Cologuard? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Results: _____
Have you had a bone density test? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Results: _____
Have you ever had a blood transfusion? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have an advance directive or living will? Yes <input type="checkbox"/> No <input type="checkbox"/>

### Pregnancy History

Total # of pregnancies	# miscarriages
# full term births	# ectopics
# premature births	# induced abortions
# living children	# multiple births
Please list any complications	

### Surgical History (include LEEP, cesareans, D&C, etc)

Surgery	Date	Why?	Details

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## History or Current Health History

Any history or current:			Details
Abuse (sexual, physical, emotional)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
ADD/ADHD	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Allergies, seasonal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Autoimmune disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Bleeding disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Blood clotting disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Crohn's or Ulcerative Colitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Chronic Back Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
COPD/Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Diabetes /Hx Gestational Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Gallbladder disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Headaches/Migraines	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Heart Disease/ Heart Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hemorrhoids	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Infertility	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Kidney Disorder (stones, infections, etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Injuries (broken bones, etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Liver Problems (hepatitis, fatty liver)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Mental Health Diagnosis (bipolar, etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Multiple Sclerosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Ovarian cysts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
PCOS (polycystic ovarian syndrome)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Seizure disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Skin conditions (eczema, acne, psoriasis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Stroke/ Deep Vein Thrombosis (DVT)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Stomach issues (GERD, hernias, ulcers, IBS, etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Thyroid disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Urinary Tract Infections (frequent)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Uterine problems (fibroids, polyps, endometriosis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other medical issue not listed above

### Family History

I don't know my family history. <input type="checkbox"/>		
Mother: Living? <input type="checkbox"/> If deceased, age? _____	Cause: _____	
Father: Living? <input type="checkbox"/> If deceased, age? _____	Cause: _____	
Siblings: How many total? _____ How many are alive? _____		
How many died? _____ If deceased, age (s)? _____ Cause(s): _____		
Illnesses		Details
Cancer – Breast	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cancer – Colon	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cancer – Ovary	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Cancer – Uterus	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Mood disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Heart Disease (heart attack)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Stroke or Blood Clots	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Alcohol or drug abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Thyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	

### Social History

Marital Status:	
Sexual History: Never sexually active <input type="checkbox"/> Not currently sexually active <input type="checkbox"/>	
Currently sexually active with:	
Sexual orientation:	Gender Identity:
Race:	Language(s) spoken:
Religious affiliation:	
Highest level of schooling:	Current job:
Nutrition:	
Exercise:	



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>In the past month</b> , have you consumed any alcohol or used other drugs? - How many <b>days per month do you drink?</b> _____ - How many <b>drinks on any given day?</b> _____ - How often did you have <b>4 or more drinks per day in the last month</b> _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you <b>smoked any cigarettes</b> in the past 3 months? If yes, list cigarettes per day _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do your <b>friends have a problem with alcohol or other drug use?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your <b>partner have a problem with alcohol or other drug use?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you <b>feeling at all unsafe in any way</b> in your relationship with your current partner or at home?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In the past, have you been in an <b>abusive domestic relationship?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Over the last few weeks, <b>has worry, anxiety, depression or sadness</b> made it difficult for you to do your work, get along with people, or take care of things at home?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>In the past</b> , have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>

### Immunizations/Screenings

	Yes	Date	No		Yes	Date	No
TDAP				Flu Shot			
Hepatitis A				Pneumococcal			
Hepatitis B				MMR			
Varicella				TB Test			
Gardasil				COVID vaccine			
Shingles				Type:			

Any additional information that we need to know to better take care of you:

Forms completed by Patient <input type="checkbox"/> Nurse <input type="checkbox"/> Provider <input type="checkbox"/> Other <input type="checkbox"/>	
Patient Signature: _____	Reviewed by: _____