Blueze Wellness

2412 E Washington St, Ste 4B • Bloomington, IL 61704
309-585-2116 • Fax: 309-585-2152
www.bluezewellness.com

2022

PATIENT INFORMATION Date Completed_____

Preferred Pharmacy_____ Pharmacy Location_____

Preferred Hospital or Surgical Facility _____

Name_____
Last Name First Name (Full Name) M.I. Preferred Name Maiden Name

Address_____
Street City and State Zip Code

Home_____Work_____ Cell _____ Preferred Phone: ☐HM ☐WK ☐CELL

Birth Date_____ Age _____ Marital Status __S __M __W __D Sex_____

Race: ___American Indian / Alaskan Native ___Asian ___Black / African American

___Natural Hawaiian / Pacific Islander___White ___ Other Race ___ Unknown ___ Decline

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Unknown ___Decline

Preferred Method of Communication for Appointment and Yearly Reminders: ___Phone ___E-mail ___Text

E-mail: _____ Employer & Occupation: _____

Emergency Contact & Relationship:_____ Emergency Phone:_____

Spouse's Name & Phone:_____

How did you hear about us? ___Friend ___Family Member ___Co-Worker ___Web Site ___Health Fair ___Doctor / ER

Who can we thank for referring you?_____

If patient is a minor, please complete this section:

Guarantor Name: _____
Last Name First Name M.I.

Address _____
Street City and State Zip Code

Guarantor Birth Date _____ Home Phone Number _____

Work Phone Number _____ Relationship to Patient_____

PRIMARY INSURANCE COVERAGE

Name of Policy Holder_____

Member ID# & Group#_____

_____

Insurance Company_____

Policy Holder's Date of Birth_____

Relationship to Policyholder:_____

SECONDARY INSURANCE COVERAGE

Name of Policy Holder_____

Member ID# & Group#_____

_____

Insurance Company_____

Policy Holder's Date of Birth_____

Relationship to Policyholder:_____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form, obtain medication history, and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

Initials

HIPAA AUTHORIZATION

Blueze LLC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes are described in our Privacy Notice and may be made in writing, orally, or by facsimile.

If there is anyone you would allow us to share information with, please list the names, relationships and phone numbers of those people below.

____ May share my protected health and financial information with:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Please mark whether we can share all information with the people listed above or list what you do not want shared:

____ No Restrictions

____ Restrictions: (Please list your requested restrictions) _____

_____

For further explanation or for a copy of our HIPAA Privacy Notice please see the front desk staff or visit our website. This release is effective until revoked by patient with written signature.

Initials

FINANCIAL AGREEMENT

= It is your responsibility to inform our office of any address, telephone number or insurance changes. You may be responsible for additional charges if your primary insurance is terminated during your medical care.

= Your account is to be kept current - accordingly, all self-pay or insurance co-payments, co-insurances, and deductibles will be collected at the time of service. Payable by cash, check, or credit/debit card. If you cannot make payment in full, a payment plan will be set up.

= If you do not have your payment(s), your appointment may be rescheduled.

= You may be asked to schedule another appointment for issues other than the reason for your original appointment.

= A returned check will result in a $50 service charge ***and*** all future payments being required in the form of cash or credit card.

= There is a $75 No Call/No Show fee if you do not give notice of needing to cancel your appointment.

= Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.

= The undersigned also agree(s) to pay all collection fees incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency, in addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

We will submit your insurance claims. However, we must emphasize that as medical providers, our relationship is with you not your insurance company. We attempt to verify your benefits. Please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

= Not all services are a covered benefit with all insurance plans

= It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.

= You are responsible for any non-covered charges not payable by your insurance policy.

= Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility.

= We realize that temporary financial problems may affect timely payment. We urge you to contact us promptly for assistance.

I authorize Blueze, LLC to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits. A copy of this authorization may be used in place of the original. I request that payment of authorized medical benefits be made on my behalf to Blueze, LLC for services furnished to me.

Initials

Your signature below indicates that you understand and agree to the above.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

We look forward to providing you with the highest quality care and trust. We hope you will find us friendly and helpful.

Updated 01/01/2022 ah

Affidavit and Letter of Intent Signature

The patient understand that this constitutes the entire agreement with Blueze, LLC.

Legal Name (printed):

_____

Signature:

_____

Date:

_____

☐ Cash

☐ Insurance

☐ Tele-monitoring

Blueze, LLC
COMMONLY PRESCRIBED MEDICATION DRUG INFORMATION

☐ I have read and understand the potential side effects that might occur when taking any of the above mentioned medications.

☐ If I am prescribed any of the above medications, I have access to a Blueze, LLC staff member and the pharmacy to answer any questions or concerns that I might have.

☐ If I don't feel comfortable taking a prescribed medication, I will notify my Blueze, LLC provider if I haven't started or have started and stopped taking the medication.

☐ I accept all responsibility for taking any medication and hold harmless Blueze, LLC, its' staff and associates should a complication arise.

☐ I attest to reading this document in its' entirety.

Legal Name (printed):

_____

Signature:

_____

Witness:

_____

Date:

_____

Blueze, LLC 12/2018

Date Completed:

Patient Name:

DOB:

Personal Past Medical History

		Date
☐	Abnormal PAP Smear	
☐	Abnormal Uterine Bleeding	
☐	Anemia	
☐	Anxiety	
☐	Arthritis	
☐	Asthma	
☐	Bleeding Disorder	
☐	Cancer: _____	
☐	Chickenpox	
☐	Chlamydia	
☐	Deep Vein Thrombosis (DVT)	
☐	Depression	
☐	DES Exposure	
☐	Diabetes	
☐	Eating Disorder: _____	
☐	Endometriosis	
☐	Epilepsy	
☐	Esophageal Reflux (GERD)	
☐	Fatigue	
☐	Fibrocystic Changes of the Breast	
☐	Fibroids, Uterine	
☐	Gastrointestinal Disorder: _____	
☐	Genital Warts	
☐	Headache	
☐	Heart Attack / Disease	
☐	Hematuria (Blood in urine)	
☐	Hepatitis	
☐	Herpes Simplex, Genital	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	Human Immunodeficiency Virus (HIV)	
☐	Human Papilloma Virus (HPV)	
☐	Incontinence of Urine	
☐	Infertility, Female	
☐	Irregular Periods	
☐	Irritable Bowel Syndrome	
☐	Kidney Disease: _____	
☐	Liver Disease	
☐	***NONE***	
☐	Osteoporosis	
☐	Other STDs: _____	
☐	Ovarian Cyst	
☐	Pelvic Inflammatory Disease	
☐	Pelvic Mass	
☐	Pelvic Pain	
☐	Polycystic Ovaries	
☐	Postmenopausal Bleeding	
☐	Premenstrual Tension Syndrome (PMS)	
☐	Previous Blood Transfusion	
☐	Psychiatric Problems	
☐	Recent Rash or viral illness	
☐	Respiratory Disorder	
☐	Sexual Dysfunction	
☐	Sickle Cell Anemia	
☐	Stroke	
☐	Thyroid Disorder	
☐	Tuberculosis (TB)	
☐	Urinary Tract Infection	
☐	Uterine Prolapse	
☐	Other: _____	
☐	Other:	

Health Maintenance

		Date
☐	Last Mammogram	
☐	Last Exam and/or pap	
☐	Last Cholesterol Check	
☐	Last Bone Density	
☐	Last Colonoscopy	

Past Surgical History

		Date
☐	Abdominal Hysterectomy	
☐	Ablation	
☐	Appendectomy (Appendix)	
☐	Back Surgery	
☐	Bladder Surgery	
☐	Breast Surgery	
☐	Cervical Procedure	
☐	Cesarean Section	
☐	Cholecystectomy (Gall Bladder)	
☐	Cryosurgery	
☐	Dilation and Curettage (D & C)	
☐	Ectopic Pregnancy	
☐	Hysteroscopy (Exploration of the Uterus)	
☐	Knee Surgery	
☐	Laparoscopy (Exploration of the Abdomen)	
☐	Lumpectomy (Breast)	
☐	***NONE***	
☐	Other	
☐	Ovarian Surgery	
☐	Thyroidectomy	
☐	Tubal Ligation / Essure	
☐	Vaginal Hysterectomy	

Allergy List

☐ *NO KNOWN ALLERGIES*

Allergic to: Reaction:

Family Medical History

M=Maternal
P=Paternal

	Disease Name	Relative	Age onset	
☐	Alzheimer's			M A P A
☐	Blood Disorder			M A P A
☐	Breast Cancer			M A P A
☐	Cervical Cancer			M A P A
☐	Colon Cancer			M A P A
☐	Diabetes			M A P A
☐	Heart Disease			M A P A
☐	High Blood Pressure			M A P A
☐	High Cholesterol			M A P A
☐	Mental Illness / Depression			M A P A
☐	***NONE***			
☐	Osteoporosis			M A P A
☐	Other			M A P A
☐	Ovarian Cancer			M A P A
☐	Stroke			M A P A
☐	Thyroid Disorder			M A P A
☐	Tuberculosis			M A P A
☐	Uterine Cancer			M A P A

Height: **Weight:**

Date Completed:

Medication List

Current Medication	Indication	Dosage	Prescribing Doctor

Genetic History

	Disease Name	Relation
	Canavan Disease	
	Congenital Heart Defect	
	Cystic Fibrosis	
	Down Syndrome	
	Hemophilia	
	Huntington Chorea	
	Mental Retardation/Autism	
	Metabolic Disorder (PKU, Diabetes)	
	Muscular Dystrophy	
	Neural Tube Defect/Spina Bifida	
	NONE	
	Other Inherited Genetic or Chromosomal D/O	
	Other:	
	Sickle Cell Anemia	
	Tay-Sachs Disease	
	Thalassemia	

Reproductive History (Menstrual)

Age at 1st Period			
Cycle Interval Days			
Menses Duration Days			
Flow	Light	Medium	Heavy
Last Menstrual Period			
Menopause Status	Pre	Peri	Post
Age Menopause			

Method of Birth Control:

Cervical Cap	Condoms	Depo Provera
Diaphragm	IUD	OCPs (BC pills)
OTC (foam, jelly, etc)	Other	***NONE***
Rhythm Method	Sterilization	Tubal Ligation
Vasectomy	Withdrawal	

Clots	No	Yes
Breakthrough Bleeding	No	Yes
On Hormone Replacement Therapy (HRT)	No	Yes

Reproductive History (Pregnancy)

Pregnancy Summary (including miscarriages, ectopic, abortion)

Total Pregnancy	Full Term	Premature	Abortion Induced	Miscarriage	Ectopics	Multiple	Living

Pregnancy Details (Anesthesia types: Epidural, General, IV Meds, Local, None Spinal)

Date	GA (weeks)	Hrs Labor	Birth WT	Sex	Delivery Type	Anesthesia	Early Labor	Complications

Social History

Have you ever been sexually active? No Yes Are you currently sexually active? No Yes

Marital Status: Bisexual Dating Divorced Engaged Lesbian Married Not-dating Single Widowed

Education Level: High School Some College/AA Degree College Graduate Degree Post Other: _____

Occupation: _____

Exercise: Sedentary Active but no formal Minimal (1 per week) Moderate (1-3 per week) Heavy (4 or more per week)

Substance Use:				Name/type	amount	age started	age stop	other information
Tobacco	*Never*	*Current*	*Former*					
Alcohol	*Never*	*Current*	*Former*					
Caffeine	*Never*	*Current*	*Former*					
Prescription ABUSE	*Never*	*Current*	*Former*					
Other	*Never*	*Current*	*Former*					
Illegal Drugs	*Never*	*Current*	*Former*					

Have you engaged in abusive behavior towards others? No Yes

Have you been emotional / physically / sexually abused or threatened by anyone? No Yes _____

Do you wear your seat belt? No Yes

Updated 5/7/19 AH

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ DOB: _____ Date: _____

	Not at all	Several Days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b. Feeling down, depressed, or hopeless	❑	❑	❑	❑
c. Trouble falling/staying asleep, sleeping too much	❑	❑	❑	❑
d. Feeling tired or having little energy	❑	❑	❑	❑
e. Poor appetite or overeating	❑	❑	❑	❑
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
g. Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	❑	❑	❑	❑
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❑	❑	❑	❑
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. 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?	❑	❑	❑	❑

For Physician use only

0 - Not at all
1 - Several Days
2 - More than half the days
3 - Nearly every day

Total score: _____

bluezen WELLNESS

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THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____