



## Adult Health History

Today's Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: \_\_\_\_\_ Primary Language: \_\_\_\_\_ Race: \_\_\_\_\_

Employment Status (please circle): Employed / Unemployed / Retired

Current/ former occupation: \_\_\_\_\_

Marital Status: Single / Married / Domestic partnership / Widow(er)

Smoking Status: Current / Former

### Primary Contact:

#### Mailing Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preferred Phone (please circle): Cell / Home / Other

Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Work: \_\_\_\_\_

Is it ok to leave a detailed message at your preferred phone number? (circle one) yes / no

Preferred Email Address: \_\_\_\_\_

Is it ok for us to email you with general updates related to Seek Optimal Health, P.C.? (circle one) yes / no

### Emergency Contact:

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

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

### Health Insurance Details:

Type (please circle all that apply): Medicare / Medicaid or Medi-Cal / Group Health Plan / Other: \_\_\_\_\_

Insurance Plan / Program Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Employer / School Name: \_\_\_\_\_

Are you currently on Medical Disability? Yes / No

Do you receive any Medicare benefits? Yes / No

**Referral Source**

Did anyone refer you to Seek Optimal Health,P.C.? (please be specific: include name of website, friend, etc): Yes / No

Referral Source: \_\_\_\_\_

**Other Healthcare Providers:**

Primary Care Physician: \_\_\_\_\_

Facility/Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_

Other Provider(s) involved in your care (Physician Specialists, Chiropractor, Naturopath, Acupuncturist, Homeopath, Dentist, etc):

\_\_\_\_\_  
Facility/Clinic(s):

\_\_\_\_\_  
Phone(s):

**Please read the following Agreements and Initial After Each if you Agree:**

**Complimentary Care Agreement**

While the services offered at Function First Integrative Health are meant to help you improve your overall health and well-being, they are not intended to take the place of a relationship with a primary care provider who offers standard recommended screening services (mammograms, pap smear, prostate exams, etc). I understand that the care I receive from Dr. Cuny at Function First is considered complimentary. I further understand that in order to receive care from Dr. Cuny I must maintain a relationship with a primary care physician of my choosing and that no physician at Seek Optimal Health, P.C. may function as my primary care physician. Initial: \_\_\_\_\_

**Payment Agreement**

I understand that I am solely responsible to pay for services rendered by Dr. Cuny at Function First according to the fee schedule discussed at the time of scheduling my first appointment (As of 06/19/23 standard fee schedule is as follows: initial 90 minute adult visits - \$475, initial 60 minute child visits - \$390, 30 min follow-ups -\$195, 60 minute follow-up - \$390). These basic office visit fees usually include osteopathic manipulation, but other office procedures offered are not generally included in this fee (injections, laser therapy, etc). I will be informed of the fee for any of these additional procedures if they are recommended to me. Initial: \_\_\_\_\_

I understand that Dr. Cuny is not contracted with any insurance programs, and payment is due at the time of service. I also understand that I may request a superbill and submit this to my insurance for reimbursement. I am responsible for any fees incurred by Seek Optimal Health, P.C. as a result of a returned or cancelled check. Initial: \_\_\_\_\_

**Medicare Recipients**

Check one:

I am a Medicare recipient:

\_\_\_\_\_ Yes

\_\_\_\_\_ No

If you answered yes above, please initial below to acknowledge that you understand that Dr. Nuño is currently opted-out of Medicare and you or we cannot request reimbursement from Medicare for office visit fees with Dr. Nuño at this time, and that a Medicare Private Contract needs to be signed before initiation of care with Dr. Nuño. Initial: \_\_\_\_\_

Dr. Cuny is a contracted Medicare provider at this time. Please initial below to provide consent for Seek Optimal Health to submit requested documentation/records necessary to our biller and Medicare for office visits with Dr. Cuny. Initial: \_\_\_\_\_

### **HIPAA**

I confirm that I have been offered a copy of a Notice of Privacy Practices for Seek Optimal Health, P.C. I also acknowledge that a copy of any amendments to the Notice of Privacy Practices will be available at each appointment or upon request. Initial: \_\_\_\_\_

### **Informed Consent for Treatment with Osteopathic Manipulation**

Osteopathic manipulative medicine is based on the following tenets: The body is a unit; the person is a unit of body, mind, and spirit. The body is capable of self-regulation, self-healing, and health maintenance. Rational treatment is based upon an understanding of the basic **principles** of body unity, self-regulation, and the interrelationship of structure and function.

Osteopathic manipulative treatments involve application of manual (hands-on) techniques centered in an understanding of functional anatomy. In general, they are both specific and gentle. Associated risks are minimal, and commonly benign.

Potential benefits of Osteopathic manipulative treatment include reduction of pain or discomfort, greater flexibility and strength, restoration of symmetry, improvement in numbness or tingling, reduction of swelling, enhancement of the body's natural healing mechanisms, and improvement in function of the body's organ systems.

Osteopathic manipulative treatment is generally painless and well tolerated. Occasionally, people do experience some temporary pain during application of the manual techniques depending on the dysfunctions present. Bruising is possible after certain techniques. Mild soreness lasting one to two days after treatment is possible, and is usually considered a normal part of the healing process. It is also common to have some temporary mild drowsiness or a lightheaded feeling immediately following treatment. Risks are extremely rare in skilled hands, but could include fracture, disc herniation, or rupture of a blood vessel. As in the practice of any form of medicine, other unexpected risks or complications may occur. If, during the course of treatment, unforeseen conditions are discovered it may be necessary to alter or discontinue osteopathic manipulative treatment.

**I acknowledge that I have read the above description about osteopathic manipulative treatment, and understand the possible risks and benefits of osteopathic manipulative treatment. I will inform the physician providing treatment at Seek Optimal Health, P.C. of any conditions I have been diagnosed with that might affect the treatment's outcome. I understand that no guarantee can be made as to the results that may be obtained with osteopathic manual therapy, or to the number of visits required for a desired outcome, since patient response is individual. I voluntarily give my authorization and consent to receive osteopathic manipulative treatment by the physicians at Seek Optimal Health, P.C.. Initial: \_\_\_\_\_**

### **Primary Reasons for Scheduling Today's Visit:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Do you have any medical records (labs or imaging studies) that would be helpful in our evaluation of your current reason for scheduling?** Please be sure to send anything pertinent to us via the online patient portal. If you are unable to access the portal, you can fax them to us at (855) 225-6308.

**Medical History (Medical conditions you have been diagnosed / treated for):**

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**Current Medications (Please include dose and frequency):**

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**Current Nutritional Supplements (Please include brand, dose, and frequency):**

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**Allergies: (Please list any allergies in the table below, along with type and severity of reaction):**

	Type of Reaction	Severity
Medication		
Food		
Environmental		

**Trauma History (Mental / Emotional / Physical / Surgeries / Broken Bones / Concussions with dates, please):**

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**Personal Birth History:**

Born by: Vaginal birth / C-section

Was assistance required? Yes / No If yes, what type? Forceps / Vacuum

Were you breastfed as a baby? Yes / No If yes, how long? \_\_\_\_\_

Did your mother receive any of the following medications? (Circle all that apply) pitocin / oral pain meds / epidural / antibiotics

Were there any complications after birth? (Circle all that apply) Trouble breastfeeding / Jaundice / Poor weight gain / Infection

**Personal Dental History:**

Do you currently have any amalgam (Silver) fillings in your teeth? Yes / No / Not Sure

Do you currently have any gold fillings in your teeth? Yes / No / Not Sure

Have you ever had a root canal? Yes / No

Have you had any dental extractions? Yes / No If yes, please describe: \_\_\_\_\_

Do you have any of the following? (Circle all that apply) Fixed bridge / Permanent retainer / Night guard / Braces /

Invisalign / ALF Please specify if you are using dental appliances not mentioned above : \_\_\_\_\_

If not currently using, have you had orthodontic braces in the past? Yes / No

Have you ever used a rapid palate expander? Yes / No

Have you had any dental implants? Yes / No

Do you have any of the following conditions? (Circle all that apply): Sleep apnea / Snoring / Bruxism (tooth grinding or clenching)

Do you have any TMJ problems? Yes / No If yes, please specify: \_\_\_\_\_

Do you generally receive regular dental exams / cleanings? Yes / No

**Women's Health (if applicable):**

Menstrual Status (please circle): Pre-menopause - regular cycles / Pre-menopause - irregular cycles / Post-menopause

Date of last menstrual cycle: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_ Date of last Pap Smear: \_\_\_\_\_

Currently Sexually Active: Yes / No

Current Birth Control Method (if applicable): \_\_\_\_\_

Have you had any difficulty conceiving or pregnancy complications in the past? Yes / No

If you answered yes to the above question, please specify: \_\_\_\_\_

Symptoms (please check all that apply):

	Current	Past Issue		Current	Past Issue
Painful menstrual periods			Difficulty Conceiving		
Painful intercourse			Vaginal discharge or itching		
Sexually transmitted infection			Fibroids		
Endometriosis			DES exposure		
PMS			Other (please specify on line below)		

**General Review of Symptoms** (please check all that apply in the tables below):

	Current	Past Issue		Current	Past Issue
Unexplained weight loss			Itchy Eyes		
Unexplained weight gain			Ringling in Ears		
Fevers			Hearing Changes		

Chills			Post Nasal Drip		
Night Sweats			Mouth Sores		
Morning Fatigue			Tooth Pain		
Afternoon Fatigue			Hoarseness/Loss of Voice		
Trouble Falling Asleep			Trouble Swallowing		
Trouble Staying Asleep			Abnormal Tastes		
Abrupt Vision Changes			Appetite Changes		
Blurred Vision			Bloating		
Double Vision			Abdominal Pain		
Eye Pain			Heartburn/Indigestion		
Pain with breathing			Irregular Heartbeats / Palpitations		
Constipation			Chest Pain		
	Current	Past Issue		Current	Past Issue
Diarrhea			Arm Swelling		
Nausea			Leg Swelling		
Vomiting			Lightheadedness / Fainting		
Blood in Stools			Productive Cough		
Yellowing of the Skin			Dry Cough		
Food Intolerances			Shortness of Breath at rest		
Stomach Ulcers			Shortness of Breath lying flat		
Mid Back Pain			Hip Pain		
Low Back Pain			Neck Pain		
Joint Pain			Upper Back Pain		
Trouble emptying bladder			Acne		
Pain with urination			Brittle Nails		
Increased frequency or urgency			Thinning Hair		
Frequent urination at night			Neck Swelling		
Blood in the urine			Tremor		
Incontinence			Heat Intolerance		
Hernia			Cold Intolerance		
Dry Skin			Excessive thirst or hunger		
Rashes			Anxiety		
Itching			Easy bruising		
Depression			Swollen glands		
Phobias			History of Lyme disease		
Dizziness			History of severe allergic reaction		
Tingling			Hives		

Numbness			Hayfever		
Trouble with coordination			History of Autoimmune Disease		
Speech changes			Anemia		
Weakness			Bleeding tendency		

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Have you had any dental extractions? Yes / No If yes, please describe: \_\_\_\_\_

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Have you ever used a rapid palate expander? Yes / No

Have you had any dental implants? Yes / No

Do you have any TMJ problems? Yes / No If yes, please specify: \_\_\_\_\_

Do you generally receive regular dental exams / cleanings? Yes / No

**Other:**

Who do you live with? (Circle all that apply) alone / pets / spouse / partner / extended family / friends / child(ren) / parents

Do you have any children? Yes / No If yes, what are their ages? \_\_\_\_\_

Have you had any long term exposures to either mold or chemicals at home or work? Yes / No

If you answered yes to the above question, please specify: \_\_\_\_\_

Do you, or have you participated in any sports now or in the past? Yes / No If yes, which

sports? \_\_\_\_\_

Please list any major sources of stress in your life. \_\_\_\_\_

How do you manage stress? (Circle one) pretty well / somewhat well / could be better / don't handle stress well at all

**Diet:**

Do you follow any specific diet program? Ketogenic / Vegan / Vegetarian / FODMAPS / GAPs / Other: \_\_\_\_\_

Dietary preferences / restrictions: \_\_\_\_\_

Do you drink any caffeinated beverages? Coffee / Tea / Energy Drinks / Soda / Other: \_\_\_\_\_

Do you drink alcohol? Yes / No If yes, about how many drinks do you have per week? \_\_\_\_\_

Please fill in the table below with a 3 day food diary:

	Day #1	Day #2	Day #3
Breakfast			

Lunch			
Dinner			

**Family History:**

Please fill in the table below with pertinent family history, if known:

	Living?	Age if living or age at death	Significant medical diagnoses
Mother	Yes / No		
Father	Yes / No		
Maternal Grandmother	Yes / No		
Maternal Grandfather	Yes / No		
Paternal Grandmother	Yes / No		
Paternal Grandfather	Yes / No		

	How many do you have?	Ages	Are they all alive?	Significant medical diagnoses
Sister(s)			Yes / No	
Brother(s)			Yes / No	

All answers to the questions above provided by me have been true and accurate to the best of my knowledge.

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

Printed Name: \_\_\_\_\_

Relationship to the patient:

Self / Parent or legal guardian (patient is a minor) / Adult to whom I have granted rights of medical guardian or conservator