Good Day to you,

Please fill out the form completely and either fax, mail to or drop off at our office. We request that you do not email this form as email is not HIPAA compliant.

Once we have received your completed form; Dr Zub and Lisa Vasile, NP will review your form to ensure 4 Better Health is the best place for your unique symptoms and conditions. Kimberly will then reach out to you to set up an initial consultation or to offer you our recommendations for another center.

When booking your appointment we will ask for a $100.00 deposit to save your spot on our calendar. Due to our specialty and wait list, we require this to keep your appointment. We have a 48 hour cancellation policy. Should you need to reschedule, the deposit will be saved for the rescheduled appt. If you reschedule more than twice, the deposit will be forfeited and you will be expected to pay 50% of the total investment for your scheduled appointment.

The investment for your consultation will be $300.00 per hour. This will be prorated for time (ie: most appointments run 1-1.5 hours which will be $300-$450 for your visit). We will offer you a formal "Superbill" form to submit to your insurance company with all of the required CPT and ICD10 codes. This form can be used towards any deductibles and for about fifty percent of our patients a partial or full reimbursement for their visits. We do take all flex spending, HSA and credit cards and offer payment programs.

We are passionate about supporting our patients with a deeper approach 4 Better Health using functional medicine testing and treatments. We look forward to working with you.

Peace & Health,

The 4 Better Health Team

P.S if you choose to mail your form, please be advised: many of our patients have their form sent back to them due to lack of sufficient postage. Please place $1.75 on the envelope for mailing. Please also keep a copy of your form for yourself.

Health History 4 Better Health

Date completed _____

As a reminder we are a Functional Medicine Practice only (ie: We do not offer Primary care or Internal Medicine) and do require you to have a Primary Care Provider. The initial appt is 60-90 minutes. The consultation includes review of this detailed health history form, lab and/or imaging review from your other providers, extensive history taking, limited exam and our immediate recommendations. We will give you a SuperBill at the end of the consultation which can be submitted to your insurance company for possible reimbursement and/or to add towards your necessary deductible limits. Please send or bring copies of recent and/or relevant testing.

We require this health history be filled out prior to scheduling to ensure our support will benefit you and to book you for the time we feel we will need for your appointment. We require a $100 deposit at the time of scheduling the initial consultation and will be happy to expedite you on our schedule as soon as we receive your completed health history.

Name: _____ DOB _____
Address:_____ Town _____ZIP CODE_____
Home # _____ Cell # _____
Email _____
Occupation: _____Hours/week _____ Employer: _____
Name of partner/spouse: _____ Marital Status: _____
List the ages and names of your children and step children
_____
Have you ever smoked? _____ How many Packs/day now? _____ Still smoking? _____

1. Allergies AND reactions
2. Hospitalizations
3. Surgeries
4. Accidents/injuries
5. Past Medical History
6. Significant childhood illnesses
7. Significant adult illnesses
8. What is your main reason for seeking care with 4 Better Health? When did this concern start? What has this condition or symptom "cost' you in life/financially?
9. Please describe your symptoms? What makes them feel better? What makes them feel worse? Are there related symptoms?
10. Have you had lab work or imaging done for the current concerns? Were the results normal?

Name & location of Primary Care Provider: _____
Date of last Physical _____
List in order of importance health problems/concerns that are troubling you:
*What do you feel/think is causing your health concern(s)?
1. _____ since: _____causes*_____
2. _____ since: _____causes* _____
3. _____ since: _____causes* _____
4. _____ since: _____causes* _____ __

Are you currently OR HAVE YOU EVER BEEN under the care of any Health care practitioners & why? *(check all that apply)*

_____Chiropractor	_____Acupuncturist	_____Massage therapist
_____Physiatrist	_____Physical Therapist	_____Homeopath
_____Medical Doctor	_____Reiki	_____Reflexology
_____Allergist	_____Oncologist	_____Cardiologist
_____Rheumatologist	_____Gastroenterologist	_____Dermatologist
_____ Counselor/Psychotherapist		_____ Neurologist

Other: _____
When do you last remember feeling really great? _____

How long do you think it'll take to improve your health concerns? *When you're thinking of how soon you want results, consider how long you've had the condition.* _____

Have you had any accidents, conditions, illnesses, injuries, surgeries or hospitalizations which affected your health in such a manner that you've never been totally well since? Y/N
If so, please list the type of condition and the approximate date it occurred: _____

Have you EVER or are you CURRENTLY using any of the following? Indicate (Y/N), the name, frequency and length of time you have taken these:

- Laxatives - Antidiarrheal _____
- Antacid - bloating _____
- Antibiotics: _____
- Probiotics _____
- Corticosteroid creams or pills: _____
- Pain killers (aspirin, Tylenol, ibuprofen, narcotics, etc.): _____
- Thyroid medication: _____
- Iron, folate, B12 _____
- Hormone Replacement: _____
- Birth Control Pill (BCP): _____
- Sleeping aides: _____
- Recreational drugs: _____
- Nasal sprays/allergy pills: _____

Have you ever had allergy testing done? _____ Was it blood, stool or skin patch testing? _____
Where there any allergies? _____

What is your Nationality (ie: Irish, English, German, etc) _____

How many course of antibiotics in your lifetime? Less than 5 _____6-10 _____10-20 _____ > 20 _____
Have you ever had a period of time when you were on/off ANTIBIOTICS? When and why?
_____
Have you ever had a period of time when you were on/off STEROIDS (prednisone, cortisone, etc)? When and why?
_____

Have you ever suffered from any of the following? Please write Past or Present (or both)
Eczema _____ Asthma _____ Sinus issues _____
Ear infections _____ Strep throat _____

What is your Height _____ Weight _____
Weight 6 months ago _____ Weight 1 year ago _____ Goal weight _____
Any weight concerns? (now/past) (gained/lost)
What have you tried to gain/lose weight? How? When?
_____
_____

How many meals do you have/day? _____ Do you skip meals? _____
Do you have any complaints with your digestion? _____
How often do you have a bowel movement? 1-2x/week _____ every other day _____daily _____ 2x/d _____ 3x/d _____more _____
Are your bowels ___ hard___ loose ___ combination___ neither ("regular") _____

How is your sleep? _____
Difficulty falling asleep?_____ Waking in the night? _____ Bed time: _____ Rising time: _____
Do you feel rested when you wake up? _____
How many hours of sleep do you get each night? _____
Do you wake in the night to urinate? _____ How many times? _____
What else wakes you at night? _____
Any dreams (recurrent/not) or nightmares? _____

What's your energy level (1-10; 10=high)? _____
Do you meditate or use relaxation techniques? _____How often? ___ ___Results? ___
Other relaxation habits? (reading, gardening, baths, meditation, etc?) _____

Do you enjoy your work? _____ Do you take vacations? _____
Do you follow any religious or spiritual/peaceful practice? ____ Please specify:
_____
What do you enjoy most in your life? _____
Do you have time for this? _____

What do you worry most about in life? _____

Is your Mom alive Y N
How old is she now or was she when she passed? _____
What medical struggles did she have? _____
Did she take medications? _____

Is your Dad alive Y N
How old is he now or was he when he passed? _____
What medical struggles did he have? _____
Did he take medications? _____

Please list the ages and health of your siblings:
_____
_____
_____

Please discuss the health of your grandparents:
MGM _____
MGF _____
PGM _____
PGF _____

Who lives with you? _____Are they supportive of you working with 4 Better Health?
Are there any other family health conditions you worry may affect you? (who had this?)
_____
_____

What relationships in your life are satisfying? _____
Do you have any relationships that are challenging? _____
How would you describe your relationship(s) with your partner/ children/ parent(s) /employer? _____

Has there been any traumatic experience or major loss in your life?
_____
Age at time of trauma: _____

Are there any incidents of physical, emotional or sexual abuse in your past?
_____

On a scale of 1-10; where would your rate exercise in your life? _____ What is your typical movement, sports or exercise each week? _____

How many glasses of each do you have daily? (0-10)
Water _____ Coffee _____Tea herbal _____ Energy drink ___ Milk ____ Sports drink ___ Juice ___
Wine ____ Beer _____ Mixed drink _____

What percentage of your food is cooked at home? ____ Where do you get the rest from?_____
What is your typical
Breakfast: _____
Lunch: _____
Dinner: _____ ___
Snacks: _____
How does this vary from how you ate as a child? _____
Do you crave sugar, coffee, cigarettes, or have any major addictions?
_____

Where have you last traveled outside of Canada/US?
_____

Exposures:
Have you been exposed to toxic chemicals (from home/where you live/work: paints, industrial cleaners, pesticides, orchards, golf courses, water, etc)
Mold? _____
How many Tattoos do you have? _____
Have you ever been tested for toxins or heavy metals? _____
Have you ever lived in a home with smokers? If so, when? _____
Have you ever had silver fillings put in your teeth? If so, when? _____
Have you ever had silver fillings replaced? If so, when? _____Was this done with a biological dentist? ____
Have you ever had a root canal? _____
Have you ever had reactions to any vaccinations, medications, or supplements?
_____
Do you use a method of birth control or protection? If so, what type do you use? _____
Have you suffered with recurrent yeast or skin infections? _____
What did you treat those with and when? OTC remedies _____
***(females) Are you still menstruating? _____ Every _____ days x _____ days Discuss pattern and if this is a concern for you: _____*
Have you ever had trouble getting pregnant or staying pregnant? Y___ N___ Please explain _____

Please list ALL medications and supplements you are currently taking and list why:

Medications:

Name of Medication	Dose	# of times day	How long have you taken this?

Supplements:

Name of Supplement	Dose	# of times/day	How long have you taken this?	Name brand of Supplement

Any else you would like us to know?

_____
_____
_____
_____

Who can we thank for referring you 4 Better Health? _____

Thank you for your time. This information is valuable for your health journey.
We look forward to supporting you 4 Better Health

HEALTH PROFILE – Multiple System Questionnaire

Name _____ **Date** _____

Rate each of the following systems based upon your typical health profile for the last 30 days (or since your last session)

Point Scale: 0 – Never or almost never have symptom **1-** Occasionally have it, effect is mild
2 – Occasionally have it, effect is severe **3-** Frequently have it, effect is mild **4-** Frequently have it, effect is severe

HEAD	
Headaches	_____
Faintness	_____
Dizziness	_____
Foggy brain	_____
Total for this section	_____
Eyes	
Watery or itchy eyes	_____
Swollen, red or sticky lids	_____
Bags or dark circles	_____
Blurred/tunneled vision	_____
Glaucoma	_____
Total for this section	_____
Ears	
Itchy ears	_____
Ear aches/infections	_____
Ringing/hearing loss	_____
Drainage from ears	_____
Total for this section	_____
Nose	
Stuffy	_____
Sinus problems	_____
Hayfever	_____
Sneezing attacks	_____
Excessive mucous	_____
Total for this section	_____
Mouth/Throat	
Chronic cough	_____
Gagging, frequent throat clear	____
Hoarse/sore throat	_____
Swollen gums, lips, tongue	_____
Canker sores	_____
Total for this section	_____
Skin	
Acne	_____
Hives, rashes, dry skin	_____
Hair loss	_____
Flushing	_____
White patches	_____
Total for this section	_____

Heart	
Irregular or skipped beats	_____
Rapid or pounding hear	_____
Chest pain	_____
Total for this section	_____
Lungs	
Chest Congestion	_____
Shortness of breath	_____
Astham, bronchitis	_____
Difficulty breathing	_____
Total for this section	_____
Digestive tract	
Nausea, Vomitting	_____
Diarrhea	_____
Constipation	_____
Bloated	_____
Belching, Passing gas	_____
Heartburn, Reflux	_____
Intestinal/Stomach pain	_____
Total for this section	_____
Joints/Muscles	
Pain or aching	_____
Arthritis	_____
Stiffness or limintation	_____
Pain, aches or tremors	_____
Feeling of weakness	_____
Swelling	_____
Total for this section	_____
Weight	
Binge eating/drinking	_____
Excessive weight	_____
Compulsive eating	_____
Water retention	_____
Craving foods	_____
Underweight	_____
Total for this section	_____
Sleep	
Falling asleep	_____
Staying asleep	_____
Total for this section	_____

Energy/Activity	
Fatigue, tired, sluggish	_____
Apathy, lethargy	_____
Hyperactivity	_____
Restlessness	_____
Total for this section	_____
Mind	
Poor memory	_____
Confusion	_____
Poor concentration	_____
Difficulty making decisions	_____
Stuttering or stammering	_____
Slurred speech	_____
Learning disabilities	_____
Poor physical coordination	_____
Total for this section	_____
Emotions	
Mood swings	_____
Anxiety, fear, Nervous	_____
Anger, irritable	_____
Panic attacks	_____
Depression	_____
Total for this section	_____
Temperature	
Chilled, cold hands/feet	_____
Hot, hot flashes	_____
Excessive sweating	_____
Total for this section	_____
Genitourinary	
Frequent urination/urge	_____
Stress incontinence	_____
Low urine flow	_____
low libido	_____
sexual dysfunction	_____
Total for this section	_____
Other	
Restless leg	_____
Frequent illness/colds	_____
Breast pain, cysts	_____
Total for this section	_____

Life Stress

During the past 2 years have you had any of the following things happen to you? If so, please indicate the degree to which those events have affected your stress level by circling one of the numbers following the item (and only those items that apply to you). Circle only one number for each event.

	Life Event	**Degree of Impact**		
		Alittle	Moderate	Severe
1.	Change in social activities	10	15	20
2.	Change in sleeping habits	10	15	20
3.	Change in residence or housing	10	20	30
4.	Change in work hours	15	20	25
5.	Change jobs, different line of work	30	35	40
6.	Change in responsibilities at work	25	30	35
7.	Change in Spiritual/church activities	15	20	25
8.	Tension at work	20	25	30
9.	Small children or teens at home	20	25	30
10.	Children with disability or 'trouble' teens	20	30	35
11.	Outstanding personal achievement	25	30	35
12.	Trouble with in-laws	25	30	35
13.	Difficulties in peer group	25	30	35
14.	Child leaving home	25	30	35
15.	Major financial change or responsibility	30	35	40
16.	Change in relationship	30	35	40
17.	Loss of close friend	35	40	45
18.	Gain of ne family member	35	40	45
19.	Libido changes or sexual difficulties	40	45	50
20.	Pregnancy or hormonal changes	40	45	50
21.	Change in health of family member	40	45	50
22.	Retirement	40	45	50
23.	Loss of Job	45	50	55
24.	Marriage or marital separation/divorce	65	70	75
25.	Personal injury or illness	45	50	55
26.	Loss of self-confidence	55	60	70
27.	Death of family member	50	60	70
28.	Injury to reputation or trouble with law	55	60	65
29.	Death of spouse or life partner	80	100	120
30.	Other			

Finding Your ACE (Adverse Childhood Experience) Score
While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?

Yes No If yes enter 1 _____

4. Did you often or very often feel that no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced? Yes No If yes enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison? Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ **This is your ACE Score _____**

Notice of HIPAA Privacy Practices

Whenever you visit a Medical Office, your visit creates Health Information. It may be a routine physical exam, or an illness or injury that you felt needed attention. Whatever the reason, new health information about you is created. We are required, by Federal Regulations, to make sure that we act only in ways that respect the confidentiality of your information, and use and disclose that information only for appropriate and necessary purposes. This notice is intended to inform you of those uses and disclosures, and to explain your rights regarding your Protected Health Information. Protected Health Information is any health information about you that includes pieces of information that could link that information to you.

The "Designated Record Site" of protected information includes your Medical Record; the records of associated information stored and used on behalf of this office by our Business Associates – other companies that we have contracted with them to perform various other functions for us, such as labs. These Business Associates are aware of their obligation to protect the confidentiality of the information they use on our behalf.

Use or Disclosure for Treatment, Payment, or Operations:

During the course of your visit, the provider may record detailed health information specific to you, your height, weight, and blood pressure, perform certain examinations and record findings, recommend supplements, or order tests, and possibly write a prescription. These pieces of information are added to your Medical Record. On, or prior to, your next visit, the record of previous visits will be reviewed. All of these events involve uses of your Protected Health Information. There are also other health professionals who may see your information. Sometimes your provider may make a referral to another medical professional such as a specialist or physical therapist. That individual receives the necessary portions of your Protected Health Information, but s/he is likewise required to treat the information in a confidential manner.

In most offices, there are individuals other than Doctors and Nurse Practitioners who handle your medical record. The person who books your appointment may also have access to your record. We take very seriously the need for our entire staff to respect you and information about you. Should you have additional concerns, you may reach out to us at any time.

Deposits & Cancellation Policy:
Due to our specialty and wait list; we require a $100 deposit to hold your appointment in our calendar. We have a 48 hour cancellation policy. Should you need to reschedule, the deposit will be saved for the rescheduled appt. If you reschedule more than three times, the deposit will be forfeited and you will be expected to pay 50% of the total investment for your scheduled appointment. Thank you for understanding.

Please initial that you have read and understand these policies _____

Patient Registration & HIPAA Acknowledgement

Patient Name: _____ Birthdate: _____

Sex: _____ Marital Status: _____ SS#: _____

Patient Street Address: _____

Patient City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

I, _____, acknowledge that I have received a copy of 4 Better Health's Notice of privacy Practices (HIPAA).

Emergency Contact: Name _____ Phone_____ Relationship:_____

Name of Primary Care Doctor: _____ Phone #:_____

(Insurance information will be used for testing purposes)

Primary Insurance Company: _____ Policy ID #:_____ Group ID # _____
Plan Name _____ Insurance Type _____
Effective date _____ Relationship to insured _____
Employer Info: Name _____ Address _____
Subscriber into: Name _____ DOB _____ Phone# _____
Address _____

Secondary Insurance Company: _____ Policy ID #:_____
Group ID # _____
Plan Name _____ Insurance Type _____

Deposits & Cancellation Policy:
Due to our specialty and wait list; we require a $100 deposit to hold your appointment in our calendar. We have a 48 hour cancellation policy. Should you need to reschedule, the deposit will be saved for the rescheduled appt. If you reschedule more than three times, the deposit will be forfeited and you will be expected to pay 50% of the total investment for your scheduled appointment. Thank you for understanding.

Please sign below to indicate that you have read and understand the privacy policy.

Patient Name (please print) **Patient's or Legal Guardian's Signature** **Date**

4 Better Health, Inc.

Medicare opt-out statement

Self-Pay Agreement and Acknowledgement Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical needs and treatment. There will be many responsibilities you will own during your journey 4 Better Health. Prompt payment of your bill is one aspect of your responsibilities as it pertains to your treatment and care. We, at 4 Better Health, have opted out of Medicare. For this reason it is necessary for you to complete and date this form for our records. Should you want a copy of this form, please ask.

I, _____, understand that as a self-pay patient, I am completely responsible for the payment of services. I understand that the initial consult visit, as well as any subsequent visits, requires full payment prior to services rendered. If I am unable to pay at the time of my visit, my visit will be cancelled and rescheduled at a time payment can be made.

I understand that because 4 Better Health, Inc has opted out of Medicare, I am prohibited to submit any claims for care at 4 Better Health to Medicare.

I understand that I am responsible for payment of services and, in case of default, I am responsible for reasonable attorney's fees and all costs of collection to include collection fees and late fees. I understand that it is my responsibility to confirm coverage with my insurance company for any tests or lab work. I also understand that I will be held responsible for any balance not paid by my insurance.

Signature & Date

We believe that a great practitioner/patient relationship is based on understanding and open communication. Please don't hesitate to contact us with further financial questions.

I attest to the fact that I have read all of the above statements and fully understand its meaning.

_____ _____

Signature **Date**

_____

Please Print your Full Name Clearly