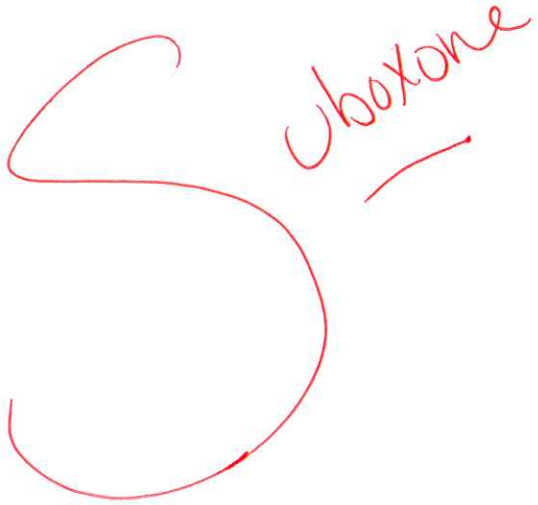
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Scales Nutrition and Wellness Center

Patient Registration

Patient's Last Name

Patient's First Name MI

Address Apartment No.

City, State, Zip Code

Home Phone Cell Phone

Email

Date of Birth Social Security

Sex (Please Circle)
Male Female

Marital Status (Please Circle)
Married Single
Divorced Widowed

Driver's License Number State

Name of Employer Phone No.

Name of Emergency Contact Phone No.

Referring Physician (if applicable):

Spouse/Parent (Please circle)

Name

Address

City, State, Zip Code

Phone Number

Insurance Information

Primary Insurance

Name of Insurance Carrier

ID Number Group Number

Secondary Insurance

Name of Secondary Insurance

ID Number Group Number

Privacy Practices (Please Initial Each Line)

____ I acknowledge that Dr. Scales office personnel has given me a copy of their Notice of Privacy Practices. I authorize Dr. Scales and/or his office personnel to communicate with family, friends, or other health care providers as to my medical conditions. Listed below are the (specific) family members or health care providers to who I give permission to discuss my health status. _____

____ The following listed names are (specific) family members or health care providers with whom I Do Not want my medical conditions discussed. _____

____ I authorize Dr. Scales or his office personnel to leave messages on my voice mail at home and work, or email.

____ I authorize other physicians or health care providers I have seen to exchange medical information with Dr. Scales, unless otherwise indicated. _____

Financial & Insurance Policy (Please Initial Each Line)

____ I hereby authorize payment of benefits processed on by behalf to Scales Nutrition & Wellness Center for any services furnished to me by Dr. Scales. Furthermore, I authorize Dr. Scales and his office personnel to release any information obtained in the course of my evaluation & treatment to permit processing of claims for insurance reimbursement. I understand I am responsible for payment of any service(s) my insurance does not pay or process in a timely matter, customarily in 60 days.

____ I understand I am financially responsible for paying my co-payments, co-insurance, deductibles and all outstanding balances. In the event that any past due balance is placed with a third party, I agree to pay any cost of such collection including the agency fees, legal/attorney fees and court cost.

____ I understand if I cancel my appointment within 24 hours of the scheduled appointment or fail to keep a scheduled appointment, I will be charged and responsible for paying twenty-five ($25) dollars for an internal medicine & medication management appointment, seventy ($70) dollars for a psychiatry appointment, fifty ($50) dollars for a therapy appointment, and appropriate charge(s) for a missed nutrition appointment.

Signature of Patient (Parent or guardian if patient is a minor) Date

Scales Nutrition and Wellness Center

2021 Church Street, Suite 602 Nashville, TN 37203 (615) 284-4432

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You may have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 14,2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (615) 284-4432.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print name_____ Signature_____ Date_____

Scales Nutrition and Wellness Center
Patient Questionnaire, Page 1 of 4

Date:_____

Name:_____ Age:_____

Occupation:_____ Marital Status: M S D W

Please indicate if you have suffered from any of the following:

asthma	jaundice	heart attack	stroke
arthritis	gout	heart murmur	tuberculosis
bladder infections	goiter	hernia	ulcer
diabetes	glaucoma	high blood pressure	cancer
epilepsy	hay fever	rheumatic fever	psychiatric disorder

Other medical problems not noted above:_____

_____

Any hospitalizations for illness, trauma, or surgery? If so, please list date and reason for hospitalization:

Date	Reason for hospitalization

Medications-Please list all medications including over the counter medications, antacids, laxatives, birth control pills, vitamins, herbs, etc.

Drug	Dose	How many times per day	Length of time taken

Allergies-Are you allergic to any medications, latex, or food? If so, please list them and the problem experienced.

Medication/Food Allergies	Problem Experienced

Name_____ Date_____

Vaccinations within the past ten years (please include date it was given):

Tetanus (Circle TT, Td, DPT)_____ MMR_____
Pneumovax _____ Hepatitis B_____
Influenza _____ HIB _____

Health Maintenance Data (include dates if known):

PPD (for TB)_____ Flexible Sig/Colonoscopy _____
Hemoccult_____ Pap Smear/PSA _____
Mammography _____ Breast/Testes _____
Stress Test _____ EKG_____
Chest X-ray_____ Echocardiogram_____

Personal Health Habits:

Do you smoke?	Y	N	How many years?_____
Have you ever smoked?	Y	N	How many years?_____
			How many packs per day?_____
Do you drink alcohol?	Y	N	How many drinks per week?_____
			Date of last drink _____
Do you exercise regularly?	Y	N	What kind of exercise?_____
			How often? _____
Do you use recreational drugs?	Y	N	What kind? _____
			How often?_____
Do you have any problems sleeping?	Y	N	How many hours per night?_____
Do you follow a special type of diet?	Y	N	What kind?_____
Have you ever been exposed to toxins or fumes at home or work?	Y	N	What kind?_____

Review of Systems:

Have you had any of the following problems? If so, which ones and when did they start?

General	No	Yes	When/Explain
Skin/rash	___	___	_____
Bruise easily	___	___	_____
Joints ever painful?	___	___	_____
Lost or gained weight	___	___	_____
Sensitive to heat/cold	___	___	_____
Head and Neck			
Frequent headaches	___	___	_____
Frequent colds	___	___	_____
Problems with vision	___	___	_____
Hearing	___	___	_____
Frequent nosebleeds	___	___	_____
Hair loss	___	___	_____
Difficulty seeing at night	___	___	_____
Taste alterations	___	___	_____
Bleeding gums	___	___	_____
Dry mouth	___	___	_____
Sore in mouth	___	___	_____

Name_____ Date_____

Chest and Cardiovascular	No	Yes	When/Explain
Shortness of breath	___	___	_____
Wheezing	___	___	_____
Chest discomfort	___	___	_____
Extremities cold/numb	___	___	_____
Swelling of hands/feet	___	___	_____
Frequent coughing	___	___	_____
Coughing up blood	___	___	_____
Daytime drowsiness	___	___	_____
Loud snoring	___	___	_____
Unrested after sleep	___	___	_____
Gastrointestinal			
Stomach pains	___	___	_____
Nausea frequently	___	___	_____
Frequent constipation	___	___	_____
Black stools	___	___	_____
Blood or pus in stool	___	___	_____
Vomiting blood	___	___	_____
Frequent diarrhea	___	___	_____
Trouble digesting foods	___	___	_____
Frequent laxative use	___	___	_____
Genitourinary			
Urinate >1 time/night	___	___	_____
Urinate > 6 times/day	___	___	_____
Burning during urination	___	___	_____
Urine brown or bloody	___	___	_____
Sexual difficulties	___	___	_____
Musculoskeletal			
Knee problems	___	___	_____
Back problems	___	___	_____
Leg cramps	___	___	_____
Joint pain	___	___	_____
Change in mobility	___	___	_____
Neurological			
Dizziness	___	___	_____
Memory loss	___	___	_____
Tremors	___	___	_____
Seizures	___	___	_____
Headaches/Migraines	___	___	_____

Name_____ Date_____

Reproductive History

For Women Only:

At what age did you first menstruate?_____
When was your last menstrual period?_____
Number of live births?_____
Number of miscarriages, stillbirths? _____
Number of abortions? _____
Do you take oral contraceptives or have an IUD? _____
Do you have problems with vaginal discharge? _____
Do you have trouble holding your urine when you sneeze or cough? _____
Do you do self breast examinations? _____

For Men Only:

Have you ever had prostate trouble?	Y	N	
Has your urine stream become weak or slow?	Y	N	
Have you had pain, swelling or lumps in your testicles?	Y	N	
Do you have any children?	Y	N	How many? _____

Family History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Asthma						
Heart disease						
Hypertension						
Rheumatic fever						
Stroke						
Cancer						
Obesity						
Depression/Mental illness						
Liver disease						
Diabetes						
Kidney disease						
Arthritis						
Sleep Apnea						
High Cholesterol						
Bleeding disorder						
Epilepsy						

Name_____ Date_____

Step 1—Questionnaire

Patient's Name: Date:

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Social Phobia Inventory

Initials _____Age _____,____Sex _____Date _____ID#_____

Please check how much the following problems have bothered you during the past week. Mark only one box for each problem, and be sure to answer all items.

	Not at all	A little bit	Somewhat	Very much	Extremely
1. I am afraid of people in authority.	0	1	2	3	4
2. I am bothered by blushing in front of people.	0	1	2	3	4
3. Parties and social events scare me.	0	1	2	3	4
4. I avoid talking to people I don't know.	0	1	2	3	4
5. Being criticized scares me a lot.	0	1	2	3	4
6. Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
7. Sweating in front of people causes me distress.	0	1	2	3	4
8. I avoid going to parties.	0	1	2	3	4
9. I avoid activities in which I am the center of attention.	0	1	2	3	4
10. Talking to strangers scares me.	0	1	2	3	4
11. I avoid having to give speeches.	0	1	2	3	4
12. I would do anything to avoid being criticized.	0	1	2	3	4
13. Heart palpitations bother me when I am around people.	0	1	2	3	4
14. I am afraid of doing things when people might be watching.	0	1	2	3	4
15. Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
16. I avoid speaking to anyone in authority.	0	1	2	3	4
17. Trembling or shaking in front of others is distressing to me.	0	1	2	3	4

From Connor K., Davidson J., Churchill L., Sherwood A., Foa E., Weisler R., "Psychometric properties of the Social Phobia Inventory". Br J Psychiatry.2000; 176:379-86.

Name_____ Date_____

Mood Questionnaire

The questions you are about to answer will help your doctor provide a proper diagnosis.
Please discuss the results of this questionnaire with your doctor.

Instructions for patients: Please check ONE BOX ONLY for each of the questions below.
The following three questions will ask you about a history of mania or "highs".

1. Has there ever been a period of time when you were not your usual self and...	YES
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐
...you felt much more self-confident than usual?	☐
...you got much less sleep than usual and found you didn't really miss it?	☐
...you were much more talkative and/or spoke much faster than usual?	☐
...thoughts raced through your head and/or you couldn't slow your mind down?	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐
...you had much more energy than usual?	☐
...you were much more active and/or did many more things than usual?	☐
...you were much more social or outgoing than usual--for example, you telephoned friends in the middle of the night?	☐
...you were much more interested in sex than usual?	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐
...spending money got you or your family into trouble?	☐

2. If you checked YES to more than one of the above, have you experienced several of these during the same period of time?	YES ☐

3. How much of a problem did any of these situations cause you (like being unable to work; havi money, or legal problems; and/or getting into serious arguments or fights)?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

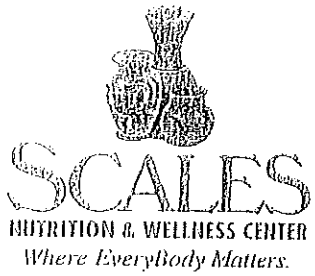
*Reprinted with permission from Robert M.A. Hirschfeld, MD.

Two questions about yourself

These questions will assess if you currently have depression

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐

AstraZ



Tom Scales, MD
Board Certified in Internal Medicine

2021 Church Street, Suite 602
Nashville, Tennessee 37203

p: 615-284-4432
f: 615-284-4529
e: dr.scales@scalesnutrition.com
i: www.scalesnutrition.com

PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. Please print legibly.

Name _____

Address _____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N Date _____

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory	( ) Cardiovascular (heart attack, high cholesterol, angina)	
( ) Hypertension	( ) Epilepsy or seizure disorder	( ) GI disease
( ) Head trauma	( ) HIV/AIDS	( ) Diabetes
( ) Liver problems	( ) Pancreatic problems	( ) Thyroid disease
( ) STDs	( ) Abnormal Pap smear	( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

If there a family history of any of the illnesses listed above, please put an "F" next to that illness

MD NOTES _____

_____

_____

Is there a family history of anything NOT listed here? (Please explain) _____

_____

_____

MD NOTES _____

_____

Have you ever had **surgery** or been **hospitalized**? (Please describe) _____

_____

_____

MD NOTES _____

_____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

_____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason _____

Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription-medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

Please list all current **herbal medicines, vitamin supplements**, etc. and how often you take them

_____

MD NOTES _____

_____

_____

Please list any allergies you have (penicillin, bees, peanuts)

_____

MD NOTES _____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _____ For how many years? _____

Pipe: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day on average? _____ For how many years? _____

Have you ever been **treated for substance misuse?** ( ) N (Please describe when, where and for how long)

_____

How long have you been **using substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? ( ) N (Please list) _____

What was your longest period of abstinence? _____

MD NOTES _____

Name/Practice Name

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name _____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/ in long-term relationship _____ Times Married _____ Times Divorced _____

Children? ( ) N ( ) Y Current ages (list) _____

Residing with you? ( ) N ( ) Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? ( ) N (Please describe) _____

Education (check most recent degree):

( ) Graduate school ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Are you currently employed? ( ) N Where (if "no, " where were you last employed?)

_____ What type of work do/did you do? _____ How long have/did you work (ed) there? _____

Have you ever been arrested or convicted? ( ) N

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

Have you ever attended:

AA ( ) Current ( ) Past NA ( ) Current ( ) Past CA ( ) Current ( ) Past

ACOA ( ) Current ( ) Past OA ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? ( ) N (Please describe) _____