BLATMAN
INTEGRATIVE HEALING

Date: _____

Dear _____,

We are excited that you are a new patient and your first visit is scheduled to be on

_____ at _____. We focus our expertise to three areas.

1. Making your pain go away. No matter what your diagnosis and no matter how long you have been in pain, there is a good chance most of it can go away. Even scoliosis in a child can be reversed if not too late.
2. Regenerative medicine – you can grow a new rotator cuff tendon; you can restore the cartilage in a worn out joint. You can grow new nerves and blood vessels in private organs, so they work better. Your pelvic floor can be restored to reduce stress incontinence. Even organs can be restored if it is not too late…. Brain from dementia, kidneys from failure, etc.
3. We also treat chronic illness where conventional medicine doesn't do well, such as fibromyalgia, chronic fatigue, Lyme, mold, dementia, kidney failure, irritable bowel, and cancer.

We will help teach you how to get out of your body's way so it can do the healing it knows how to do. And then we will help facilitate your body's work to make the changes and healing needed to accomplish your healing needs.

Whether you are a child, adult, elderly, or professional athlete, we have more than 30 years of experience that can help you where nothing else has worked.

Our tools include:
Nutrition, body work, trigger point injections, prolotherapy, prolozone, compounding pharmacy, bio-identical hormones, platelet-rich plasma, stem cells, exosomes, peptides, ARPWave, darkfield microscopy for live blood and mouth analysis, IV therapies including vit C, ozone, ultraviolet blood irradiation, mistletoe, hydration, immune boosting and more, genetic analysis and lab analysis to optimize nutrition and care, and more.

Your work: take some time and complete the medical history form which has been provided in your packet. For some this is quick, others can take a while. Please write or type this information and bring in your packet to the first office visit.

Also enclosed are our General Information and Financial Policy Information. These will explain how our office functions. We ask that you the “patient” contact your insurance company so you can be advised of your medical out of network benefits.

A map to our office and a checklist of things to bring with you is enclosed for your convenience.

WE HAVE RESERVED A CONSIDERABLE AMOUNT OF TIME FOR YOU. IF YOU NEED TO CANCEL THIS VISIT YOU MUS CALL AND GIVE US AT LEAST 72 HOURS NOTICE OR YOU WILL BE CHARGED THE $100 DEPOSIT FOR THIS RESERVED TIME.

We look forward to meeting you. If you have any questions, please do not hesitate to call.

Yours truly,

Hal S Blatman MD and Staff

BLATMAN INTEGRATIVE HEALING

120 East 56th Street
12th Floor
New York, NY 10022
513-956-3200 fax 513-956-3202
www.BlatmanHealthAndWellness.com

GENERAL INFORMATION

OFFICE HOURS

Our office hours are from 9:00AM until 5:00PM, Thursday through Friday. Cincinnati is open Monday through Thursday.

PHARMACY/PRESCRIPTION REFILLS

All patients are asked to phone their pharmacy for refills, and have the pharmacy fax a refill request for more efficient and timely service. We must have **48 hours notice** for your prescription medication to be filled; no prescriptions will be filled otherwise. Prescriptions will not be refilled in the evening or on weekends. And please remember we are not open on Fridays! When calling the office for refills, please spell your first and last name, and also be sure to tell us what medications are needed as well as the pharmacy number.

PHONE CALLS/EMAILS

Calls of a medical nature are often handled by our staff. If your call requires the doctor's attention, it will usually be returned after office hours. Please leave a number where you can be reached at those times.

APPOINTMENTS

All patients must complete our patient information registration form. All paperwork sent to each new patient should be completed prior to arriving at our office. Failure to have paperwork completed may force us to reschedule your appointment.

We make every effort to stay on schedule. Emergencies and unpredictable situations sometimes arise and affect our schedule. We ask for your patience if you should have to wait.

CONFIDENTIALITY

Your medical records are strictly private and confidential. No information from your chart will be given to family members, your employer, your attorney or other doctors without your written permission. Worker's Compensation patients have already signed a release for medical records in order to be seen by the Ohio BWC.

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Office Hours are 8:00AM to 5:00PM, Monday through Thursday
Our office is closed Friday, Saturday and Sunday

FINANCIAL POLICY

We welcome you to our office, and we are pleased to have this opportunity to help you as a patient. We are providing this information to help you understand how our business office operates, and to acquaint you with the policies of our practice.

We are committed to providing you with the best possible care, and we are always willing to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions about our fees, financial policies, or your financial responsibility, please call our financial coordinator.

PAYMENT METHODS

We accept cash, money orders, and Major Credit Cards.

INSURANCE

We are not a participant in any insurance plans. Most insurance company networks do not cover our treatment completely. It is your responsibility to contact your insurance company prior to your office visit**. Payment for services in full is due at the time services are rendered**. We will provide you with a superbill that has diagnosis and procedure codes as appropriate. You must realize however, that your insurance company is a contract between you, your employer and the insurance company. We are not a party to that contract. Again, we urge you to check with your company before your first visit regarding your out of network benefits.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

OVER PLEASE

APPOINTMENTS

We schedule 90 minutes for a new patient visit. If you cancel your new patient office visit, you must let us know at least 72 hours in advance of your appointment, or you will be charged $100.00. As an established patient, if you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. This courtesy allows us to be of service to other patients. You will be charged a $75.00 no show fee if you cancel less than 24 hours prior to your scheduled time and this charge must be paid prior to your next office visit.

If your account does fall behind and we are forced to send it to a collection agency, you will be further charged a $50.00 fee as well as any other fees associated with the collecting of the money owed. These rates are all subject to change without notice.

CONFIDENTIALITY

Your medical records are strictly private and confidential. No information from your chart will be given to family members, your employer, your attorney or other doctors without your written permission. Worker's Compensation patients have already signed a release for medical records in order to be seen by the Ohio BWC.

I have read the financial policy of Blatman Integrative Healing and agree.

_____

Patient Date

CHECKLIST OF ITEMS TO BRING TO YOUR NEW PATIENT OFFICE VISIT
PLEASE FILL OUT ALL APPLICABLE SECTIONS OF PAPERWORK.
(Be aware some forms are two sided)

◊ REGISTRATION

◊ FINANCIAL POLICY

◊ PATIENT INFORMATION RECORD

◊ CURRENT MEDICAL HISTORY

◊ WHO MAY WE SPEAK TO REGARDING YOU

◊ PATIENT CONSENT FORM

◊ PRIVACY POLICY

◊ FINANCIAL POLICY

PHARMACEUTICAL RECORDS FROM PAST SIX MONTHS IF RELEVANT
(ASK YOUR PHARMACY TO FAX THESE TO 513-956-3206)

LIST OF ALL MEDICINES INCLUDING OVER THE COUNTER MEDICATIONS, SUPPLEMENTS & VITAMINS TAKEN IN THE PAST.

LIST OF ALL MEDICAL ALLERGIES - list in patient history

LABS: BLOOD WORK - RECENT, MRI REPORTS, CT SCAN REPORTS, X-RAYS - FILMS AND REPORTS IF RELEVANT

INSURANCE CARD, DRIVER'S LICENSE OR STATE I.D.

PAYMENT (CHECKS NOT ACCEPTED FOR FIRST VISIT), CASH, MAJOR CREDIT CARDS

PLEASE DO NOT SMOKE IN VEHICLE BEFORE APPOINTMENT OR ON DRIVE TO OFFICE.

PLEASE DO NOT WEAR ANY PERFUME OR COLOGNE THE DAY OF YOUR APPOINTMENT
DUE TO PATIENT AND STAFF ALLERGIES AND CHEMICAL SENSITIVITIES.

ALSO A REMINDER:

IF YOU NEED TO CANCEL YOUR APPOINTMENT FOR ANY REASON, WE SET ASIDE 2 HOURS FOR YOUR VISIT AND WE REQUIRE AT LEAST A 72 HOUR NOTICE OR YOU WILL BE CHARGED $100 FEE FOR THIS RESERVED TIME.

PATIENT INFORMATION RECORD
PLEASE PRINT LEGIBLY

DATE OF INJURY OR DATE SYMPTOMS STARTED: _____ DATE TODAY: _____

PATIENT FIRST NAME MIDDLE INITIAL	LAST NAME	SINGLE	WIDOWED
		MARRIED	DIVORCED
STREET ADDRESS	CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )	
BIRTHDATE AGE	PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S CELL NUMBER ( )	
LIST ANY OTHER NAME YOU HAVE USED	OCCUPATION	PHARMACY NUMBER ( )	
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	EMAIL ADDRESS	
NAME OF INSURANCE SUBSCRIBER	BIRTHDATE	OCCUPATION	
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	EMPLOYER TELEPHONE **EXT** ( )	

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
MOTHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )

INSURANCE INFORMATION
MUST BE FILLED OUT COMPLETELY

PRIMARY INSURANCE _____ PHONE NUMBER _(_____)_____

SUBSCRIBER NAME _____ EFFECTIVE DATE: _____

MEMBER NUMBER _____ GROUP NUMBER _____

WORKERS COMPENSATION CL# _____ MCO NAME _____

CLAIMS REPRESENTATIVE _____ MCO PHONE NUMBER _____

EMPLOYER AT DATE OF INJURY _____ DATE OF INJURY _____

PLEASE INTITIAL TO VERIFY ALL THE INFORMATION ABOVE IS CORRECT _____

OVER PLEASE

ADDITIONAL INFORMATION

FAMILY PHYSICIAN _____ REFERRING PHYSICIAN _____

STREET ADDRESS _____ STREET ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

TELEPHONE __(_____)_____ TELEPHONE __(_____)_____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP TO YOU: _____

STREET ADDRESS: _____ TELEPHONE: _(_____)_____

CITY, STATE, ZIP CODE: _____

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

□ PARENT □ SIGNIFICANT OTHER □ SELF

NAME OF PARENT OR SIGNIFICANT OTHER (GUARANTOR)_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

GUARANTOR SIGNATURE: _____ DATE: _____

THE OFFICE OF HAL S. BLATMAN, M.D., INC WILL PROCESS YOUR PRIMARY INSURANCE CLAIM AS A COURTESY TO YOU, HOWEVER, THE GUARANTOR IS FULLY RESPONSIBLE FOR ALL CHARGES REGUARDLESS OF INSURANCE COVERAGE.

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE ALL PAYMENTS MADE BY THE INSURANCE COMPANY TO BE PAID DIRECTLY TO HAL S. BLATMAN, M.D., INC.

PATIENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: (IF MINOR) _____ DATE: _____.

Please print, and check the appropriate items

Skim through entire form before starting to fill this out.

Long answers may be continued on a separate sheet of paper.

CURRENT MEDICAL HISTORY

Patient name _____

Date of birth _____ Age _____ Today's Date _____

Who referred you? _____

Family Physician _____ Doctor's Phone _____

Address of family physician _____

_____

What are your Major Concern(s) _____

_____

_____

_____

_____

_____

What are your Other Concerns and when did they start _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

When did your major concern(s) begin (be specific) _____

_____

Pain and Problem History:

What seemed to really start it? If it was an injury, how did it happen? _____

_____

_____

_____

IF
you were involved in any auto accident(s), please include details about, seat belt, shoulder strap, air bag, position in the car, make and year of what hit you, how the accident(s) happened, treatment right afterwards, symptoms or change in symptoms after the injury, etc.

Have you had this diagnosed? (year) _____ What was the diagnosis? _____

Name of physician who diagnosed it: _____

Specialty of physician: _____

Address or general location of physician: _____

What kinds of treatment have you tried? When? And what were the results of each? _____

Include physical therapy, Chiropractor, Massage, Doctors, Clinics, Acupuncture?

Please make sure you help me understand how your condition developed over time… from when it started, until now:

If you have separate treatment histories for other conditions, please summarize them on a separate sheet of paper.

What home remedies have you tried for these conditions?

What do you do that makes it better or improves your symptoms?

What do you do that makes it feel worse?

List the weather conditions you feel best in: _____

List the weather conditions you feel worst in: _____

DIAGNOSTIC TESTING—Please bring a paper copy of test reports, and the actual films of plain x-rays if possible.

Don't copy the test report into this table.

Lab tests, Blood tests, MRI scan reports, CT scan reports, EMG reports etc.

TEST NAME	DATE TEST was DONE	FACILITY where test was DONE	WHAT RESULTS WERE YOU TOLD?

What SURGERIES have you had?

SURGERY	DATE	REASON for SURGERY	SUCCESSFUL?

Continue on separate sheet of paper if needed.

REVIEW OF SYSTEMS

Please check any symptoms that are bothersome to you NOW.

General

___Poor appetite	___Bleed/bruise easily	___Poor balance	___Change in appetite	___Fevers
___Poor sleeping	___Weight loss	___Weight gain	___Sweat easily	___Chills
___Fatigue	___Strong thirst	___Localized weakness	___Tremors	___Night sweats
___**Cravings for:**	___Sweets	___Fats	___Salty food	___Other_____

Skin & Hair

___Rashes	___Loss of hair	___Pimples	___Dandruff	___Recent moles	___Eczema	___Hives
___Ulcerations	___Itching	___Change in hair	___Change in skin	___Herpes	___ Finger nails chip/crack/peel	___ Other

Cardiovascular

___High blood pressure	___Varicose veins	___Chest pains	___Irregular heartbeat
___Low blood pressure	___Fainting	___Cold hands	___Cold feet
___Phlebitis	___Swelling feet	___Swelling hands	___Blood clots
___Difficulty breathing	Other _____		

Head, Eyes Ears Nose & Throat

___Concussions	___Jaw clicks (TMJ) L or R	___Tooth problems	___# of teeth pulled
____# of silver fillings	___# Root canals	___Eye pain	___Poor vision
___Migraine	___Other headache	Type of headache _____	___Sores on lips/tongue
___Sinus problems	___Nose bleeds	___Spots in front of eyes	___Trouble with night vision
___Grinding teeth	___Facial pain	___Trouble with taste or smell	___Glasses
___Ear aches	___Cataracts	Other_____	

Immunology

Rheumatoid disease? ___Y ___N	Tested for Lyme disease? ___Y ___N	Diabetes? ___Y ___N	Thyroid problems? ___Y ___N
Cancer? ___Y ___N What Kind _____	Hepatitis? ___Y ___N What Kind_____	AIDS? ___Y ___N	Breast implants? ___Y ___N What Kind_____
Other communicable disease? _____			

Respiratory

___Cough	___Shortness of breath with minimal exercise	___Difficulty breathing when lying down	___Pain with deep breath
___Coughing blood	___Pneumonia	___Asthma	___Shortness of breath
___Bronchitis	Other _____		

Gastrointestinal

___Nausea	___Abdominal pain/cramps	___Indigestion	___Hemorrhoids	___Constipation
___Vomiting	___Diarrhea	___Black stools	___Belching	___Gas
___Rectal pain	___Blood in stools	___Bad breath	___Heartburn	___Pancreatitis
How many bowel movements a day_____	How many bowel movements a week ____	Other _____		

Genitourinary

___Pain with urination	___Frequent urination	___Blood in urine	___Urgency to urinate
___Unable to hold urine	___Kidney stone #:___	___Decrease in flow	___ Wake up to urinate
___Problem with sexual function	___Impotency	___Loss of libido (desire)	___ Pain with intercourse
___Sexually transmitted disease or exposure	___Sores on genitals	Other:	

Pregnancy & Gynecology

Pregnant? ___Y ___N	Planning a pregnancy? ___Y ___N	Post menopausal? ___Y ___N	Menopause symptoms? ___Y ___N
First date of last menses: _____	Unusual character (heavy/light) _____	Hot flashes? ___Y ___N	Fibrocystic breast ___Y ___N
___Clots	___Painful periods	___Irregular periods	___Vaginal discharge
___Vaginal sores	___Breast lumps	Birth control ___Y ___N	Type of birth control :
# of children: _____	# of C-section delivery(s)___	# of vaginal delivery(s) ___	# of abortion(s) _____
Ages of children _____	_____		

Musculoskeletal

__ Muscle pain	__ Muscle weakness	__ Jaw pain	__ Face pain	__ Neck pain
__ Shoulder pain	__ Elbow pain	__ Arm pain	__ Wrist pain	__ Hand pain
__ Finger pain	__ Upper back pain	__ Lower back pain	__ Hip pain	__ Thigh pain
__ Knee pain	__ Leg pain	__ Ankle pain	__ Foot pain	__ Toe pain
__ Osteoporosis	__ Scoliosis	__ Chest pain	__ Other:_____	_____

Neuropsychological

___Seizures	___Dizziness	___Loss of balance	___Lack of coordination
___Poor memory	___Concussion	___Depression	___Anxiety
___Bad temper	___Easily susceptible to stress	___Treated for emotional problems	___Aneurysm
Ever considered suicide? ___Y ___N	Ever attempted suicide? ___Y ___N	Areas of numbness? ___Y ___N	Where?
Other _____			

Other information you think is important that did not come up during review of systems:

Place check mark in box

Family History

	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Heart disease						
High Blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/seizures						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						
Osteoporosis						
Fibromyalgia						
Other						

Additional History

Childhood illnesses: _____

Childhood accidents and any lasting effects: _____

_____

_____

_____

_____

_____

Current Medications

Current medications	Who prescribed them	What are they for	Are they helpful

Pharmacy

Current pharmacy: _____

Address or location: _____

Phone: _____

Allergies to medication and environment:

Medication allergies—list medicine and reaction:

Environmental allergies—list agent and reaction:

History of allergy testing and treatment:

Have you ever smoked Tobacco? Y N How many packs per day? _____ Now ?_____

How many years a smoker? _____ How many times did you quit? _____When?_____

Do you have a history of alcohol or drug abuse? Treatment for abuse? Please explain:_____

_____

_____

_____

_____

_____

Diet:

red meat — number of meals per week _____

milk — number of glasses per week _____ or per day _____

cheese — number of times per week _____ or per day _____

coffee or tea — number of cups per week _____ or per day _____.

soda — number of cans per week _____ or per day _____,

what kind usually? _____

other sugar — what sweets do you usually eat and how much? _____

_____

bread — what kind and how much? _____

which do you use margarine or butter? _____

what cooking oils do you use?_____

what are your favorite foods?_____

_____

_____

Vitamins: what do you take, and why (only list why for unusual supplements or herbs)?

_____

_____

_____

_____

Sleep: how well do you sleep? _____

If not well, why not? _____

_____

_____

What position do you sleep in? _____

_____

Do you use a pillow? what kind? where placed? _____

_____

_____

Do you have stomach sensitivity to aspirin? _____Y ____N

Do you have irritable bowel? _____ for how long? _____

How is this treated? _____

_____

Who is the treating doctor? _____

Do you have a history of ulcer or indigestion? _____ Y ____ N please explain: _____

_____

_____

_____

How is this treated and who is the doctor? _____

_____

_____

When was your last complete physical examination? _____

For what reason?_____

_____

What is your occupation? _____What was your occupation?_____

If you are disabled, when did you last work? _____

What is your disability caused by? _____

Anything else you would like us to know? _____

_____

_____

_____

_____

_____

What are your goals for this treatment? What do you expect to be able to change?
with regard to your pain and your life? If you are not working, do you plan to return to work, and how soon?
How hard are you willing to work to reach your goals?

_____

_____

_____

_____

_____

_____

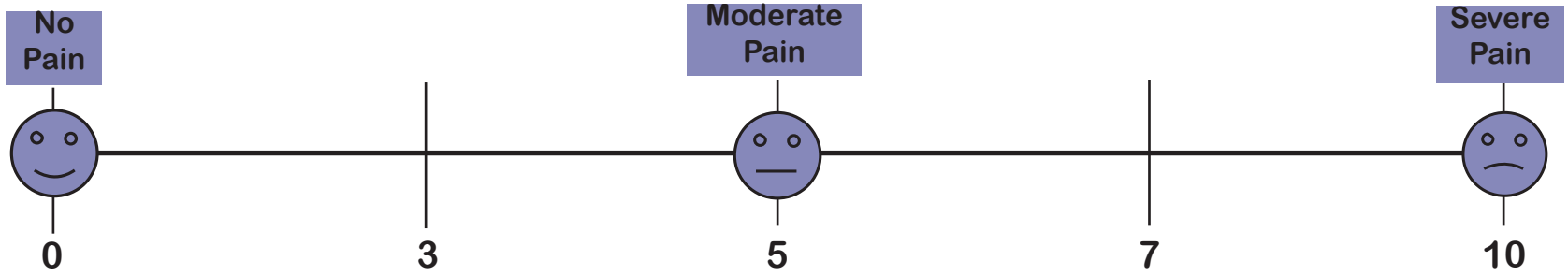
To the best of my knowledge, this is complete and accurate.

Signed: _____ ***Date:*** _____

PAIN SCALE

BLATMAN
HEALTH AND WELLNESS CENTER

0 = No Pain
1 = You are slightly uncomfortable. Occasional minor twinges. No medicine needed.
2 = Pain is a minor bother. No medicine needed.
3 = Pain is annoying enough to be distracting. Mild painkillers like Aspirin or Tylenol help.
4 = Pain can be ignored if you are really involved; it is still distracting. Mild painkillers help for 3-4 hours.
5 = Pain can't be ignored for more than 30 minutes. Mild painkillers help for 3-4 hours.
6 = Pain can't be ignored, but you can still work. Stronger narcotic painkillers help for 3-4 hours.
7 = It is hard to concentrate. Pain bothers sleep. You can still function. Pain-killers only help some.
8 = Your activity is limited a lot. You can read and talk with effort. Nausea and dizziness are part of the pain.
9 = You are unable to speak. You are crying out or moaning.
10 = You are unconscious. Pain makes you pass out.



Zung Self-Rating Depression Scale (SDS)

Reply to questions using one of the four replies below (A – D)
A – Little or none of the time
B – Some of the time
C – A large part of the time
D – Most or all of the time

	A Little or none of the time	B Some of the time	C A large part of the time	D Most of the time	
1. I feel downhearted and blue	1	2	3	4	☐
2. Morning is when I feel the best	4	3	2	1	☐
3. I have crying spells or feel like it	1	2	3	4	☐
4. I have trouble sleeping at night	1	2	3	4	☐
5. I eat as much as I used to	4	3	2	1	☐
6. I still enjoy sex	4	3	2	1	☐
7. I notice that I am losing weight	1	2	3	4	☐
8. I have trouble with constipation	1	2	3	4	☐
9. My heart beats faster than usual	1	2	3	4	☐
10. I get tired for no reason	1	2	3	4	☐
11. My mind is as clear as it used to be	4	3	2	1	☐
12. I find it easy to do the things I used to do	4	3	2	1	☐
13. I am restless and can't keep still	1	2	3	4	☐
14. I feel hopeful about the future	4	3	2	1	☐
15. I am more irritable than usual	1	2	3	4	☐
16. I find it easy to make decisions	4	3	2	1	☐
17. I feel that I am useful and needed	4	3	2	1	☐
18. My life is pretty full	4	3	2	1	☐
19. I feel others would be better off if I was dead	1	2	3	4	☐
20. I still enjoy the things that I used to	4	3	2	1	☐

Some questions ask the information positively and others negatively but in all cases the **symptom severity is Scored from 1 to 4. The total score is often converted to a 100 point scale (SDS index)**
SDS Index = (score / 80 total points) x 100 or SDS Index = score x 1.25

Total SDS raw score	

SDS Index (score x 1.25)	