Consent for Treatment

I understand that the orthomolecular modality used by Mensah Medical, LLC, utilizes nutrient protocols for treatment.

By signing this form, I agree to participate in this modality with the understanding that even with the highest level of compliance, desired outcomes are not guaranteed and that levels of response may vary.

Signed by: ______________________________________ ___________________________________

Signature of Patient or Legal Guardian Relationship to Patient

______________________________________ ___________________________________

Print Patient's Name Date

____

Print Legal Guardian's Name, if applicable

For Office Use Only

Date received by Mensah Medical: ________________________________Received by: _________________________

Mensah Medical, LLC

Health History Form

Date:___________________________

Name:____ DOB_____________________ Sex: M or F

1. Education: (Last grade completed) ____________________

2. Significant birth events or traumas: ____

____

3. Injuries / Head traumas: ____

____

4. Surgeries: ____

____

5. Number of Pregnancies: _____________________

6. Seasonal Allergies: ________________________ ________________________

________________________ ________________________

7. Food or Chemical Sensitivities: ________________________ ________________________

________________________ ________________________

8. Present Medication: Past Medications:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

9. Primary Diagnosis: ____________________

10. Other Diagnosis: ____________________ ____________________

____________________ ____________________

Name:____

11. Favorite Foods: ____________________ ____________________

____________________ ____________________

12. Sleepy after meals? ____________________

13. Sleep Problems? ____________________

14. Good Dream Recall? ____________________

15. Cigarette Smoker? ____________________ How many per day? ____________________

16. Do you / Have you used recreational drugs? ____________________ How frequently? ________________

17. Do you drink alcohol? ____________________ How frequently? ________________

18. Do / Did you enjoy school? ____________________ A B C OR D Student? _________

19. Short fuse or anger challenged? ________________

20. Tendency for Anxiety? ____________________

21. Special Hobbies? ____________________

22. Competitive in Sports Activities? ____________________

23. Do you experience depression? _______ Often Sometimes Never Not sure

24. Pain Threshold: High Low Avg

25. Do you function or cope well under stress? __________

Name:____

Circle all that apply to you:

poor stress control	poor short term memory	sensitive to bright lights
sensitive to loud noise	morning nausea	loves salt and spicy foods
skips breakfast	pale skin	poor tanning
mood swings	temper tantrums	reading disorder
under-achiever	frequent infections	pre-mature gray
white spots on nails	menstrual irreg.	ringing in the ears
poor muscle development	perfectionism	fruity breath or body odor
stretch marks	"stitch in the side pain"	phobias
strong willed	obsessions	negative demeanor
joint pains	delayed puberty	poor wound healing
dark urine	psoriasis / eczema	"night owl"
heart murmur	delusional thoughts	hallucinations
social isolation	dry mouth	music / art / creative ability

Circle all that apply to relatives:

temper tantrums	ADD/ADHD	cancer	
panic disorder	anxiety	dementia	asthma
ulcers	heart disease	stroke	bipolar disorder
kidney ds.	depression	autism	psoriasis / eczema
diabetes	arthritis	schizophrenia	

HIPAA Authorization Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). By signing this authorization, I permit **Mensah Medical, LLC** (the "Practice") to use and/or disclose individually identifiable health information (PHI) about my medical history, lab results and outcomes of any therapies provided only under the following conditions:

- with my permission or at my (the patient's) request.
- the purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.
- the Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing information without my consent or participation.

VOICE MAIL MESSAGES: Please initial in the space provided next to each of the following permissions **if you are in agreement:**

I give the Practice permission to leave a medical message on my:

_____ Home voice mail Phone: ____

_____ Work voice mail Phone: ____

_____ Cell phone voice mail Phone:____

If I cannot be reached directly or by voice mail, the Practice may leave a message with my:

_____ Spouse Name: ___________________________ Phone: ________________________________

_____ Parent Name _____________________ Phone: ________________________________

_____ Other: _________________________________ Phone: ________________________________

Please read and sign here if you agree to the following statement: **If I cannot be reached directly or by voice mail, please do not leave a medical message.**

____

EMAIL COMMUNICATION: The Practice cannot send private medical information by email due to privacy concerns. However, the Practice does utilize email communication for appointment reminders and general announcements of new or updated services, programs, research, clinic locations, seminars, and research.

_____ I do not want to receive email communication.

_____ I consent to receive email communication as described above.

Email address (if the patient is a minor, please list the email address of the parent or legal guardian):

____@ __________________________________

Email address is ☐ Self ☐ Parent or Legal Guardian

I do not have to sign this authorization in order to receive treatment from Mensah Medical. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subjected to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to written revocation must be submitted to the Privacy Officer at:

Mensah Medical, LLC
4355 Weaver Parkway, Suite 110
Warrenville, IL 60555

Signed by: ____ ___________________________
Signature of Patient or Legal Guardian Relationship to Patient

_________________________________ ___________________________
Print Patient's Name Date

____
Print Legal Guardian's Name, if applicable

For Office Use Only
Date received by Mensah Medical: ______________________________Received by: _______________________

Mensah Medical, LLC

Date: ________________________

PATIENT NAME: Last _______________________________ **First** ________________________ **Middle Initial**________

DOB: ______/______/______ **Sex**: M or F **Social Security** # (last 4 digits): ____________

Home Phone: (__________)________________________

Address: **Cell Phone**: (__________)________________________

____

____

Zip Code: _______________________

Email: ____________________________________

Occupation: ____ Disabled Retired Student

Employer Phone: (_________)________________________________

If Patient is a minor: Mother's Name: ____

Father's Name: ____

Legal Guardian: ____

Emergency Contact: ____ Phone: (_________)_____________

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Other: ______________________

GUARANTOR: **Last**___________________________________ **First** _________________________ **Middle Initial**______

DOB: ____/____/____ **Sex**: M or F **Social Security** # (last 4 digits): ___________

Address: **Home Phone**: (__________)________________________

____ **Cell Phone**: (___________)________________________

____

Zip Code: ________________________

Email: ____________________________________

Occupation: ____ Disabled Retired Student

Employer Phone: (___________)_______________________

Permission for Disclosure

PATIENT NAME:

Last ______________________________ **First** ________________________ **Middle Initial**________

DOB: ______/______/______ **Sex**: **M or F**

I, ____, give permission to:
(Printed Name of Patient)

(Printed Name of Person)	(Relationship)	(Telephone)
(Printed Name of Person)	(Relationship)	(Telephone)
(Printed Name of Person)	(Relationship)	(Telephone)

to communicate with the staff of Mensah Medical, LLC on my behalf.

Signed by: ____________________________________ ________________________________
Signature of Patient or Legal Guardian Date

____
Print Legal Guardian's Name, if applicable

For Office Use Only
Date received by Mensah Medical: ______________________________Received by: ________________________