INTEGRATIVE HEALTH

Patient Information

Date: ____________________________ File #: (office use) _____________

Name: ____

E-Mail Address: ____

Address: ____

___________________________________,________,_____________

City State Zip

Sex: ❑ M ❑ F Age: ____ Birthdate: ____/_____/________

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Social Security Number: _____________________________________

Occupation: ____

Employer: ____

Employer Address: ____

Employer Phone: ____

Spouse's Name: ____

Spouse's Birthdate: ____/_____/_______ SS# ___________________

Occupation: ____

Spouse's Employer: ____

Name of Primary Care Physician: ____________________________

May we contact him/her? ❑ Y ❑ N

Doctor's Use

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Phone Numbers

Home: _______________________ Cell: ______________________

Work: ___________________ Best to reach you at: ❑H ❑C ❑W

IN CASE OF EMERGENCY! CONTACT:

Name: _______________________________ Relationship: ______________

Primary Phone Number: ____

Secondary Phone Number: ____

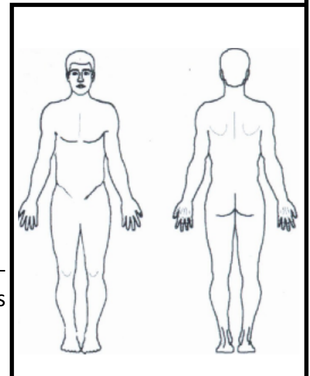
Patient Condition

Reason For Visit:____

When did your symptoms appear? ____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ I Do Not Know

→→→→→→ Circle on the picture where you have pain and draw lines where the pain radiates. →→→→→→



Is there anything you do that makes the pain worse? _______________________ Better? ____________________

Type of Pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramping ❑ Stiffness ❑ Swelling ❑ Other___________

Where does the pain radiate to? ❑ Shoulders ❑ Arms ❑ Hands ❑ Fingers ❑ Legs ❑ Feet ❑ Knees

How often do you have the pain? _____________________ Is it constant? ❑ Y ❑ N Comes and goes? ❑ Y ❑ N

Does it interfere with your… ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities and/or movements that are painful to perform… ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down

Please Circle **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

Other Chiropractors: ____ Positive Experience? ❑ Yes ❑ No

How did you become aware of INTEGRATIVE HEALTH?

❑ Referral from patient Referring patient:____________________

❑ Television Which channel?: ______________________________

❑ Radio Which station?: _________________________________

❑ Internet Which website?:_______________________________

❑ Newspaper Which paper?:______________________________

❑ Telephone Directory

❑ other: ____

Did you get X-Rays or an MRI for your condition?

❑ X-Rays Where was this taken?: ____________________________

Date taken: __________________

❑ MRI Where was this taken?: ____________________________

Date taken: __________________

Doctor's Use ____________________

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Health History (The Doctor Will Not See You Unless You Fill This Out Completely.)

What treatments have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other ____________________

Name of other doctors who have treated you for your condition

____

Condition	Y	N
AIDS/HIV	❑ Y	❑ N
Alcoholism	❑ Y	❑ N
Anemia	❑ Y	❑ N
Appendicitis	❑ Y	❑ N
Arthritis	❑ Y	❑ N
Asthma	❑ Y	❑ N
Bleeding Disorders	❑ Y	❑ N
Bronchitis	❑ Y	❑ N
Cancer	❑ Y	❑ N
Chemical Dependency	❑ Y	❑ N
Chicken Pox	❑ Y	❑ N
Diabetes	❑ Y	❑ N
Eating Disorder	❑ Y	❑ N
Emphysema	❑ Y	❑ N
Epilepsy	❑ Y	❑ N
Gonorrhea	❑ Y	❑ N
Gout	❑ Y	❑ N
Headaches	❑ Y	❑ N
Heart Disease	❑ Y	❑ N
Hepatitis	❑ Y	❑ N
Hernia	❑ Y	❑ N
Herpes	❑ Y	❑ N
High/Low Blood Pressure	❑ Y	❑ N
High Cholesterol	❑ Y	❑ N
Kidney Disease	❑ Y	❑ N
Liver Disease	❑ Y	❑ N
Measles	❑ Y	❑ N
Migraines	❑ Y	❑ N
Miscarriage	❑ Y	❑ N
Mononucleosis	❑ Y	❑ N
Multiple Sclerosis	❑ Y	❑ N
Mumps	❑ Y	❑ N
Osteoporosis	❑ Y	❑ N
Pacemaker	❑ Y	❑ N
Parkinson's	❑ Y	❑ N
Pneumonia	❑ Y	❑ N
Polio	❑ Y	❑ N
Prostate Issues	❑ Y	❑ N
Psychiatric Care	❑ Y	❑ N
Rheumatoid Arthritis	❑ Y	❑ N
Rheumatic Fever	❑ Y	❑ N
Scarlet Fever	❑ Y	❑ N
Stroke	❑ Y	❑ N
Shingles	❑ Y	❑ N
Thyroid Issues	❑ Y	❑ N
Tonsillitis	❑ Y	❑ N
Tuberculosis	❑ Y	❑ N
Tumors/Cysts	❑ Y	❑ N
Typhoid Fever	❑ Y	❑ N
Ulcers	❑ Y	❑ N
Vaginal Infection	❑ Y	❑ N
Venereal Disease	❑ Y	❑ N
Whooping Cough	❑ Y	❑ N
Other ____________________		

Exercise	❑ None	❑ Moderate	❑ Daily	❑ Heavy
Work Activity	❑ Sitting	❑ Standing	❑ Light Labor	❑ Heavy Labor
Habits	❑ Smoking	❑ Alcohol	❑ Coffee/Caffeine	❑ High Stress Level
	Packs/Day ______	*Drinks/Week* ______	*Cups/ Day* ______	*Reasons* ____________

Injuries/Surgeries you have had: **Description**

Falls ____________________

Head Injuries ____________________

Broken Bones ____________________

Surgeries ____________________

Medications __________ __________ __________ __________

__________ __________ __________ __________

Vitamins/Herbs __________ __________ __________ __________

Female Patients **Are You Pregnant?** ❑ Y ❑ N **Are You Nursing?** ❑ Y ❑ N **Date Of Last Cycle** _____/_____/_______

- **I authorize and give consent for the Doctors and/or staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**
- I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Integrative Health, LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- Our policy requires payment in full for all services at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting you account.
- **I fully understand all of the above information, and I guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in medical status.**

Signature ____________________ **Date:** ______/______/________