

MEDICATION / ALLERGIES

Allergies or reactions to food or medication: No Known Drug Allergies

PAST MEDICAL HISTORY

	Response		If Yes, Date	Reason for Hospitalization
	Yes	No		
Have you ever been HOSPITALIZED?				
#1				
#2				
#3				
#4				
Prior SURGERY	Yes	No		Reason for Surgery
#1				
#2				
#3				
#4				

FAMILY HISTORY (check appropriate box for family history)

	Alive	Deceased	Age	Healthy	Diabetes	Hypertension	Heart Disease	Lung Dz	Stroke	Cancer	Comment
Father											
Mother											
<input type="checkbox"/> Daughter <input type="checkbox"/> Son											
<input type="checkbox"/> Daughter <input type="checkbox"/> Son											
<input type="checkbox"/> Daughter <input type="checkbox"/> Son											
<input type="checkbox"/> Daughter <input type="checkbox"/> Son											
<input type="checkbox"/> Daughter <input type="checkbox"/> Son											
<input type="checkbox"/> Brother <input type="checkbox"/> Sister											
<input type="checkbox"/> Brother <input type="checkbox"/> Sister											
<input type="checkbox"/> Brother <input type="checkbox"/> Sister											
<input type="checkbox"/> Brother <input type="checkbox"/> Sister											
Relative											
Relative											
Relative											

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed

Occupation:

Education Level:

Use of Tobacco: Never Yes, how much? # of years: Quit for ____ years

Use of Alcohol: Never Yes, how much? # of years:

Use of Street Drugs: Never If yes, describe:

Physical Activities: Active Yes No If yes, # of times per week: Limited due to:

Any religious/cultural practices that would affect your care:

REVIEW OF SYSTEM

	Check any that apply or "None"
Neuro	<input type="checkbox"/> None <input type="checkbox"/> Headache <input type="checkbox"/> Convulsions <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> ADD <input type="checkbox"/> Stroke <input type="checkbox"/> Other
Psych	<input type="checkbox"/> None <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Stress/Excess Worry <input type="checkbox"/> Drug/Alcohol Issues <input type="checkbox"/> Other
Eyes	<input type="checkbox"/> None <input type="checkbox"/> Visual Problems <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Red Eyes <input type="checkbox"/> Eye Pain <input type="checkbox"/> Other
Nose	<input type="checkbox"/> None <input type="checkbox"/> Nasal Allergies <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Frequent nose bleed <input type="checkbox"/> Other
Ears	<input type="checkbox"/> None <input type="checkbox"/> Hearing problems <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Discharge <input type="checkbox"/> Other
Throat	<input type="checkbox"/> None <input type="checkbox"/> Swallowing difficulty <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Speech problems <input type="checkbox"/> Other
Mouth	<input type="checkbox"/> None <input type="checkbox"/> Dental problems <input type="checkbox"/> Tongue problems <input type="checkbox"/> Canker sores <input type="checkbox"/> Other
Neck	<input type="checkbox"/> None <input type="checkbox"/> Swollen glands <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other
Chest	<input type="checkbox"/> None <input type="checkbox"/> Chest pain <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> + TB Test <input type="checkbox"/> Other
Heart	<input type="checkbox"/> None <input type="checkbox"/> Murmurs <input type="checkbox"/> Palpitations <input type="checkbox"/> Valve problems <input type="checkbox"/> Mitral Valve problem <input type="checkbox"/> Angina <input type="checkbox"/> Other
Intestinal	<input type="checkbox"/> None <input type="checkbox"/> Heartburn <input type="checkbox"/> Reflux <input type="checkbox"/> Colitis <input type="checkbox"/> Gastritis <input type="checkbox"/> Polyps <input type="checkbox"/> Constipation <input type="checkbox"/> Bleeding <input type="checkbox"/> Other
Urinary & Genital	<input type="checkbox"/> None <input type="checkbox"/> Frequency <input type="checkbox"/> Burning <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Infection or STD <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Urinary stream
Extremity and spine	<input type="checkbox"/> None <input type="checkbox"/> Pain in: <input type="checkbox"/> arm <input type="checkbox"/> wrist/hand <input type="checkbox"/> shoulder <input type="checkbox"/> ankle <input type="checkbox"/> neck <input type="checkbox"/> mid back <input type="checkbox"/> herniated disk
Systemic	<input type="checkbox"/> None <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Loss of energy <input type="checkbox"/> Arthritis

CONSENT TO MEDICAL TREATMENT

I hereby authorize Center for Integrated Medicine, its employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the physician may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or physician as to the results of the treatments, examination or otherwise that may be obtained.

ASSIGNMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XVIII of the Social Security Act that may cover professional services rendered to the above name mentioned assignee.

FINANCIAL AGREEMENT

I agree to pay any balance of the charges over and above the above mentioned benefits. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any information to any insurance company or third party payor for the purpose of obtaining payment for services provided. I authorize release of any information to any physicians, skilled facility or other health care facility to which I may be admitted or that is involved in my medical care.

PATIENT / RESPONSIBLE PARTY SIGNATURE:	DATE:
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