

## Integrative Healthcare Partners # \_\_\_\_\_ Medical

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail address \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male or Female \_\_\_\_\_

Please circle:      Single                  Married                  Widowed                  Separated                  Divorced

Home ph. \_\_\_\_\_ Work ph. # \_\_\_\_\_ Cell ph. # \_\_\_\_\_

Medical Doctor Name \_\_\_\_\_ Phone # \_\_\_\_\_

\*Pharmacy Name\* \_\_\_\_\_ Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Home ph. # \_\_\_\_\_ Cell ph. # \_\_\_\_\_

Please name the person who referred you here \_\_\_\_\_

### Health Insurance Information

Ins. Co. name \_\_\_\_\_ Ins. carried under Self, Spouse, Parent or Step Parent?

Name of insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

The employers name that covers the insured  
\_\_\_\_\_

ID / Group # on insurance card \_\_\_\_\_

I authorize the use of this information for insurance billing, the release of information to the insurance company, I am responsible for my charges for services, and authorize payment to Spine & Neuromuscular Assoc. of S.E.I., P.S.C., and permit a copy of this authorization to be used in place of the original. Your insurance policy is between you and your insurance company. We will file your claims as a courtesy to you however; you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles. Co-payments are due at the time of service. **"NO SHOWS" WILL BE BILLED** if you don't give us 48 hour notice.

**MEDICARE DMEPOS SUPPLIER STANDARDS**  
The products and/or services provided to you by (d.b.a. Healthy Pursuit Medical Center, S.E.I) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulation Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://ecfr.gpoaccess.gov>. Upon request we will furnish you a written copy of the standards.

Signed \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_

### Patient History Form

#### History

This Section is for the purpose of learning more about your health history. Please read and answer the entire following questions to the best of your knowledge.

#### Reason for Consultation

What health concern and symptoms bring you to the clinic?

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What would you most like to achieve with this health consultation?

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Are you currently under the care of a physician or health professional for a medical / health condition(s)? \_\_\_ Yes or \_\_\_ No If yes, please list condition (s):

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History**

**Please Circle**

**Please Circle**

Significant Illness Last 5 years Yes or No

Musculoskeletal Disorder Yes or No

Significant Injury Last 5 years Yes or No

Musculoskeletal Surgery Yes or No

Digestive or Liver Disease Yes or No

Dizziness Spells Yes or No

Cardiovascular Disease Yes or No

Fainting Spells Yes or No

Cardiovascular Surgery Yes or No

Head Injury Yes or No

Hypertension Yes or No

Loss of Consciousness Yes or No

Cardiovascular Medication Yes or No

Paralysis Yes or No

Pacemaker Yes or No

Seizure Activity Yes or No

Shortness of Breath Yes or No

Sleep Disorder Yes or No

Ear Disorders Yes or No

Sleep Disorder TX Yes or No

Mouth Disorders Yes or No

Stroke Yes or No

Nose Disorders Yes or No

Alcohol Abuse Yes or No

Throat Disorders Yes or No

Alcohol Treatment Yes or No

Diabetes Yes or No

Substance Abuse Yes or No

Thyroid Disease Yes or No

Substance Treatment Yes or No

Thyroid Medication Yes or No

Anxiety Medications Yes or No

Insulin Yes or No

Nervous Disorder Yes or No

Eye Disorder Yes or No

Psychiatric Disorder Yes or No

Genitourinary Disease Yes or No

Psychiatric Medications Yes or No

Kidney Disease Yes or No

Notes: \_\_\_\_\_

Lung Disease Yes or No

\_\_\_\_\_

List of surgeries and the date of the surgeries \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Vitals: Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

List any medications you are currently taking and include Nutritional Supplements, Vitamins, Herbs, Homeopathic remedies. Attach List if you need additional space

<u>Name of Medication</u>	<u>Date Started</u>	<u>Date Stopped</u>	<u>Dosage (amt/#daily)</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

Medication Allergies, Please List:

Environmental/Food Allergies:

\_\_\_\_\_

<u>Preventive Test:</u>	<u>Month/Year of last test</u>	<u>Tests Results (if known)</u>
Cholesterol	_____	_____
Bone Density	_____	_____
Colonoscopy	_____	_____
Exercise Stress Test	_____	_____
Digital Rectal Exam	_____	_____

**Family History** (Write the relationship of the relative(s) with the disease on the adjacent lines)

- Heart Disease       yes  no      \_\_\_\_\_
- High Blood Pressure       yes  no      \_\_\_\_\_
- Diabetes       yes  no      \_\_\_\_\_
- Arthritis       yes  no      \_\_\_\_\_
- Skin Disorders       yes  no      \_\_\_\_\_
- Breast Cancer       yes  no      \_\_\_\_\_
- Uterine/Ovarian Cancer       yes  no      \_\_\_\_\_
- Prostate Cancer       yes  no      \_\_\_\_\_
- Colon Cancer       yes  no      \_\_\_\_\_
- Other Cancer       yes  no      \_\_\_\_\_

List any other disease/condition in the family and relationship? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Women

ARE YOU PREGNANT? YES NO First day of last menstrual cycle \_\_\_\_\_

Date of last pap/pelvic/breast exam \_\_\_\_\_ Results: normal abnormal

Date of last mammogram \_\_\_\_\_ Results: normal abnormal

Do you perform monthly self-breast exams yes no

Are you currently taking or have you in the past taken hormones or oral contraceptives yes No

If yes, please list all hormones and oral contraceptives you have taken and when

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any problems or concerns about taking hormone replacement therapy? yes No

If yes please list problems: \_\_\_\_\_

\_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many children? \_\_\_\_\_

Have you had a hysterectomy? yes no If yes, were your ovaries removed? yes no

Have you had any menstrual irregularities? yes no (if yes please explain) \_\_\_\_\_

\_\_\_\_\_ Has your abdominal girth and weight been increasing? yes no

Men

Date of last prostate exam: \_\_\_\_\_

Are you concerned with loss of muscle mass, tone, or strength? yes no

Have you had problems with urination (decreased stream, frequent night urination) yes no

Do you perform periodic testicular self-examination? yes no

Has your abdominal girth and weight been increasing? yes no

Additional Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY and PERSONAL HEALTH HABITS**

**General** (check all that apply)

My health is excellent good fair poor

My physical fitness is excellent good fair poor

I am under a lot of stress  I am fatigued all the time  I am having difficulty dealing with stress.

I practice meditation or other relaxation techniques  I am often sad and blue

**Dietary Habits**

No special diet habits  Avoids red meat Minimizes fat Minimizes Carbs Vegetarian

Emphasize fruits, grains and vegetables  I try to eat a healthy diet

I do not eat Dairy/cheese  I commonly eat at fast food restaurants

I commonly consume: Coffee Regular soft drinks Diet Soda Candy/Chocolate

**Exercise Habits**

No special exercise habits  I routinely exercise \_\_\_hr(s) \_\_\_X/week

Aerobic exercise (jog/walk/treadmill) Lift weights Swim

Stretch/Yoga/Tai Chi/Chi Gong Other \_\_\_\_\_

**Tobacco Use**

I never smoked cigarettes or chewed tobacco

I now smoke \_\_\_ packs of cigarettes per day. I have smoked for \_\_\_ years

I quit smoking in \_\_\_ (mo/yr). I smoked \_\_\_ packs/day for \_\_\_ years

I smoke cigars/pipe

**Alcohol Use**  I never drink alcohol  I drink occasionally or socially  I regularly drink  1-2 drinks/day  more than 2 drinks/day  more than 4 drinks/days

Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

