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?

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

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):

_____
_____
_____
_____
_____
_____
_____

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

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

Medication Allergies, Please List:

_____ **Environmental/Food Allergies:**

_____

Preventive Test:	Month/Year of last test	Tests Results (if known)
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_____/_____/_____

Patients Name: _____ Date: _____

CANCELLATION POLICY

_____**(Initial)** A 48 hour notice is required for all cancellations. If your cancellation is less than 48 hours or you do not show for your appointment, a rescheduling fee will apply before your next appointment. This is for the consideration of our patients that are waiting for a sooner appointment and allows us the necessary time to contact them with sooner appointment availability. We thank you for understanding regarding this policy that has proven to be very successful in meeting our patients' medical needs.

_____ _____

Patient Signature Date

Practitioner comments on above: _____