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Patient Health History Form

Patient Information

Name: _____

Date: ____/____/____

Date of Birth: ____/____/____

Age: ____ Gender: M/F

Marital status: S M D W

Height: ____ Weight: ____

Address: _____ City: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Would you be interested in receiving our free monthly E-newsletter? Y N

Occupation: _____ Employer: _____

How did you here about our clinic? _____

Primary Care Physician: _____ Phone number: _____

Please list all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Reason for Visit

Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

Do you have any reason to believe you may be pregnant? If so, how far along are you?

Do you have any infectious diseases? If yes, please identify:

Lifestyle

Do you typically eat at least three meals per day? Y N If no, how many? _____

How many glasses of water do you drink per day? _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Hours/Week at work _____ Do you enjoy work? Y N

Why/Why not? _____

Nicotine/Alcohol/Caffeine Use _____

Have you experienced any major traumas? Y N

Explain _____

Personal Medical History

Hospitalizations, Surgeries, X-Rays, CAT Scans, MRIIs, Special Studies

Reason When Reason When

Emotional (mark 'C' for current and 'P' for past)

Mood Swings Nervousness Mental Tension Sudden Anger
 Depression Nightmares Addictions Obsessive behavior

Energy and Immunity (mark 'C' for current and 'P' for past)

Fatigue Slow Wound Healing Chronic Infections
 Cancer Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (mark 'C' for current and 'P' for past)

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts
 Tearing/Dryness Impaired Hearing Ear Ringing Earaches
 Headaches Sinus Problems Nose Bleeds Frequent Sore Throats
 Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory (mark 'C' for current and 'P' for past)

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
 Persistent Cough Pleurisy Shortness of Breath Asthma
 Tuberculosis Other Respiratory Problems _____

Cardiovascular (mark 'C' for current and 'P' for past)

Heart Disease Chest Pain Swelling of Ankles
 High Blood Pressure Palpitations/Fluttering Stroke Anemia
 Heart Murmurs Rheumatic Fever Varicose Veins

Blood Pressure ___/___ When was this taken? _____ Blood Type _____

Gastrointestinal (mark 'C' for current and 'P' for past)

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain
 Passing Gas Heartburn Belching Gall Bladder Disease
 Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Genito-Urinary Tract (mark 'C' for current and 'P' for past)

- Kidney Disease Painful Urination Frequent UTI Frequent Urination
 Heavy Flow Urinary Dribbling Kidney Stones Impaired Urination
 Blood in Urine Frequent Urination at Night

Female Reproductive/Breasts (mark 'C' for current and 'P' for past)

- Irregular Cycles Breast Lumps/Tenderness Heavy Flow Clotting
 Bleeding Between Cycles Vaginal Discharge Premenstrual Problems
 Nipple Discharge Menopausal Symptoms Difficulty Conceiving
 Painful Periods Low Libido

Menstrual/Birthing History

Age of First Menses _____ # of Days of Menses _____ Length of Cycle _____

of Pregnancies _____ # of Miscarriages _____ # of Abortions _____

of Live Births _____ Birth Control Type (past and current) _____

Male Reproductive (mark 'C' for current and 'P' for past)

- Sexual Difficulties Prostate Problems Testicular Pain/Swelling
 Penile Discharge Low libido

Musculoskeletal (mark 'C' for current and 'P' for past)

- Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain
 Mid Back Pain Low Back Pain Leg Pain
 Joint Pain (if so, where?) _____

Neurologic (mark 'C' for current and 'P' for past)

- Vertigo/Dizziness Paralysis Numbness/Tingling
 Loss of Balance Seizures/Epilepsy Memory Loss

Endocrine (mark 'C' for current and 'P' for past)

- Hypothyroid Hypoglycemia Hyperthyroid
 Diabetes Mellitus Night Sweats Feeling Hot or Cold

Dermatological (mark 'C' for current and 'P' for past)

- Eczema Hives Shingles Acne
 Rosacea Psoriasis Warts Rashes

Is there anything else we should know? _____

Acknowledgement of Receipt of Privacy Policy

Your signature below acknowledges that you have received Notice of our Privacy Practices.

Signature: _____ Date: _____

For Motor Vehicle or Workers Comp Patients

Auto/Worker's Comp Insurance

In condition due to accident? Auto Work Accident date: _____

Claim filed? Y N

Claim # _____

Insurance company: _____

Financial Policy

Unless prior arrangement is made, full payment is due at the time of service. Payment may be made by cash, personal check, Visa, or MasterCard. For patients paying **in full** at the time of services, there is a 20% discount on all services. This does not apply to supplements, insurance co-pays or deductibles.

For your convenience, we will bill your insurance provider. We will contact your insurance company for verification of benefits.

However, insurance companies may reimburse differently than the information they initially provide to us. You are responsible for and will be billed for any resulting unpaid balance. If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service. You are expected to pay your deductible if it is still due, your co-payment, for any non-covered services, and for all supplements and products at the time of service.

Please provide us with notice of cancellation at least 24 hours in advance of your scheduled appointment. If cancellation notice is less than 24 hours, or you fail to come for a scheduled appointment, there will be a \$50.00 fee.

Accounts greater than 30 days past due will be charge a \$10 administrative fee. Accounts greater than 90 days overdue will be sent to a collections agency, unless you are making timely payments on an approved payment plan. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service.

There will be a \$35.00 fee for a returned check.

Financial Agreement:

- I have read the policies above and understand them.
- I understand that I will be provided a copy of this policy at my request.
- I agree to promptly pay all fees and charges for treatment provided to me and/or my family.
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- Should legal action be taken by this office to collect an unpaid balance due for services provided, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

These policies are subject to change without notice.

I have read, understood and agree to the policies described above:

Signature: _____

Date: _____