Account#:_____

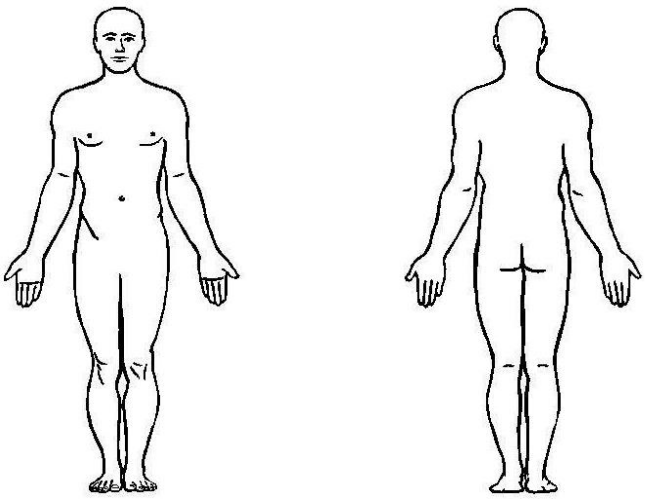
MEDICAL HISTORY INTAKE

Today's Date_____ Signature of Patient_____
First Name_____Last Name _____ Middle_____
Date of Birth _____
Address _____ City_____State_____Zip Code_____
Mobile Phone _____Secondary Phone_____
Email _____
Marital Status *(check one)* ❑ Single ❑ Married ❑ Other_____
Employment Status *(check one)*
❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed
SSN _____ (must have for all insurance patients)
Race *(check one)*
❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean
❑ Vietnamese ❑ Native Hawaiian or other Pacific Island ❑Samoan ❑ Guamanian or Chamorro
❑Other_____❑ I choose not to specify

If you are in pain, please mark the exact location of your pain on the diagram below. Use symbols to describe the type and location of pain. Use the lines on right side of page to describe any activity which aggravates/brings

Referred to this office by_____

X-Sharp #-Dull Ache *-Numbness 0-Tingling +-Burning



Major Complaint
(Please describe your major problem)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did this condition develop? (What caused it? How did it start?)_____
_____
_____

When was the first time that you were aware of this problem? (Date):_____
Have you ever had this problem or similar problem before? (If yes, then explain):_____
_____
Have you ever received any treatment for this problem before? (If yes, then where, when and what were your results):_____

Has this problem been getting better, worse or staying the same?_____

Is there anything you do that makes your condition worse? _____
_____

How has this condition affected your life?
A. Home/Recreational Life:_____
B. Occupational Life:_____
C. Rest & Sleep Life: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **2)** _____

What surgeries have you had? _____
_____

Have you ever been in an automobile or work related accident? __Past Year __Past 5 Years __Over 5 Years __Never

Did you receive any injuries? Please describe: _____
_____

CHECK SYMPTOMS YOU HAVE EXPERIENCED:

___Headache	___Irritability	___Numbness in Toes	___Faced Flushed	___Feet Cold
___Neck Pain	___Chest Pain	___Shortness of Breath	___Buzzing in Ears	___Hands Cold
___Neck Stiff	___Dizziness	___Depression	___Loss of Balance	___Cold Sweats
___Fatigue	___Head Seems too Heavy	___Loss of Memory	___Fainting Spells	___Back Pain
___Tension	___Stomach Upset	___Light Bothers Eyes	___Loss of Smell	___Constipation
___Ears Ring	___Loss of Taste	___Numbness in Fingers	___Sleeping Problems	___Nervousness
___Fever	___ Diarrhea	___Pins & Needles in Arms		

Have you ever had care by the following health providers?
❑ Medical Doctor ❑ Chiropractor ❑ Acupuncturist ❑Foot Care ❑ Nutritionist ❑ Weight Loss Coach ❑ Life Coach ❑ Massage Therapist ❑ Nurse Practitioner ❑ Physical Therapist ❑ Mental Health Counselor

Fees for examination, X-ray, and treatments are payable at time of your visit, unless other arrangements are made in advance. X-rays remain the property of this office. I authorize claims for services provided in this office by Integrative Medicine & Holistic Wellness Center LLC to be billed through paper submission or an authorized claims clearinghouse.

Patient's Signature_____**Date**_____
_____