true health
MEDICINE, PC

Promoting true health and healing.

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PERSONAL INFORMATION

Name:_____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone # (home):_____ (cell): _____ E-mail address: _____

Insurance? No / Yes Insurance Name:_____ Phone #:_____

Policy/ID Number:_____ Group Number: _____

S.S#:_____ Age: _____ Date of Birth: _____ Gender: Female ____ Male____

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single:_____ Partnership:_____

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends_____ Alone_____ Other_____

Occupation: _____ Hours per week: _____ Retired: _____

Employer: _____ Phone #: _____

Address: _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

Next of kin or other to reach in an emergency: _____

Relationship: _____ Phone: _____

Address: _____

GENERAL HEALTH REVIEW

Are you currently receiving healthcare? Y / N If yes, where and from whom: _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance:

1) _____
2) _____
3) _____

What is your reason for coming in today?

_____

_____

_____

CURRENT MEDICATIONS & SUPPLEMENTS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

GENERAL HEALTH HISTORY

Family History: Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hay fever/Hives	Osteoporosis	Metal Sensitivity	

Any other relevant family history? _____

Childhood Illnesses: Please circle whether you had any of these as a child:

Scarlet fever Diphtheria Rheumatic fever Mumps Measles German measles

Hospitalization, Surgery, Imaging: What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____Year:_____ _____Year:_____

_____Year:_____ _____Year:_____

_____Year:_____ _____Year:_____

Allergies: Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

General: Height: _____Weight:_____ lbs. Weight 1 year ago_____lbs.

Maximum Weight: _____lbs. When: _____

When during the day is your energy the best?_____worst? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Habits

Main interests and hobbies:_____

Do you exercise? Y N

If yes, what kind?_____ How often? _____

Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	how many hours? _____	
Any major traumas?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	how many hours? _____	
Been treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? _____		Drink black/green tea?	Y N P
How many packs per day? _____		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what?_____

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to vaccinations?	Y N P	Chronic infections?	Y N P
Chronic Fatigue Syndrome?	Y N P	Slow wound healing?	Y N P
Chronically swollen glands?	Y N P		

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Night Sweats?	Y N P
Lumps?	Y N P	Hair Loss?	Y N P

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

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Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	Shortness of breath while lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall Bladder disease?	Y N P	Is this a recent change?	Y N
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

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Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Male Reproduction

Hernias?	Y N P	Chlamydia?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Testicular masses?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Sexually transmitted infections?	Y N P
Sexual orientation: _____		Gonorrhea?	Y N P
Erectile dysfunction?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type? _____		Syphilis?	Y N P

Female Reproduction / Breasts

Age of first menses? _____		Date of last annual exam/ PAP _____	
Age of last menses? (if menopausal) _____		Are cycles regular?	Y N
Length of cycle? _____ days		Bleeding between cycles?	Y N P
Duration of menses? _____ days		Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms?		What type? _____	
_____		Number of pregnancies: _____	
_____		Number of live births: _____	
Endometriosis?	Y N P	Number of miscarriages: _____	
Ovarian cysts?	Y N P	Number of abortions: _____	
Abnormal Pap?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Are you sexually active?	Y N
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Difficulty conceiving?	Y N P	Condyloma?	Y N P
Breast pain/tenderness?	Y N P	Syphilis?	Y N P
Do you do breast self-exams?	Y N P	Gonorrhea?	Y N P
Breast lumps?	Y N P	Herpes?	Y N P
Nipple discharge?	Y N P	Sexual orientation: _____	

Thank you for your time and effort. We look forward to providing you with the best possible care.

I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges of all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

I give my consent for these services. I will consult with my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature:_____ **Date:**_____