

Integrative Primary Care Associates, LLC

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www.integrativeprimarycare.com

New patient health history

General information

Name _____ Age _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Telephone (home) _____ (work) _____ (cell) _____

Single Married Separated Divorced Widowed

Living situation: alone friends partner spouse parents

Number of children _____

Occupation _____ Employer _____

Employer address _____

Employment status: full-time part-time school retired unemployed other

Name of Partner/Spouse/Parent: _____

Circle one

Emergency contact _____ Relationship _____

Address _____ Telephone _____

How did you hear about us? Phone book _____ Insurance _____ Other _____

Referred by another patient? _____ Name: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS

I hereby authorize the release of any medical information necessary to in the processing of my medical claim. I also authorize payment directly to Integrative Primary Care Associates for the medical benefits.

I authorize my practitioner to examine and treat me, to consult with another healthcare practitioner in regards to continuing my care.

I certify that the information that I have supplied on this form is correct and accurate to the best of my knowledge.

Signed _____ Date _____

Patient, parent or guardian of minor

In your opinion, what are your most important physical, emotional, or mental health problems?
Indicate which is/are of the most immediate concern to you.

1. _____
2. _____
3. _____
4. _____
5. _____

Is your **main** concern related to any of the following?

- _____ Motor vehicle accident
- _____ Work related injury
- _____ Other accident or injury

How do you rate your overall health? Excellent Good Fair Poor
Circle one

What are your expectations for today's visit?

What are your expectations for our work together in general?

Frequent ear infections, colds or skin problems as a child?

Any difficulties with your birth or your mother's pregnancy?

Hospitalizations

What hospitalizations or surgeries have you had? What happened and when did they occur?

Special studies

What diagnostic imaging studies have you had? (i.e. X-rays, CT scan, mammogram, MRI, bone density scan, EKG, EEG)

Blood work

Date of last blood test? _____ What tests did you have(if known)

Allergies: reactions to any medicine, food, or other

What do you react to and what happens:

Childhood Illnesses

Rubella (German, 3 day measles) _____ Measles (two week) _____ Roseola _____
Whooping cough _____ Chicken pox _____ Mumps _____
Rheumatic Fever _____ Asthma _____ Polio _____
Scarlet Fever _____ Diphtheria _____

Immunizations

Polio Y N Pertussis Y N
Tetanus Y N Date of last: _____ Diphtheria Y N
Measles/Mumps/Rubella (MMR) Y N Hepatitis A Y N B... Y N
HPV Y N Meningitis Y N Other _____

Your health history

Now	Past	Never		Now	Past	Never	
___	___	___	Allergies	___	___	___	Heart Murmur*
___	___	___	Anemia	___	___	___	High Blood Pressure
___	___	___	Arthritis	___	___	___	Injury (serious)
___	___	___	Asthma	___	___	___	Kidney Disease
___	___	___	Alcoholism	___	___	___	Liver Disease
___	___	___	Bleeding problem	___	___	___	Overweight
___	___	___	Cancer	___	___	___	Pneumonia
___	___	___	Candida(yeast)	___	___	___	Polio
___	___	___	Colitis	___	___	___	Abnormal Pap test
___	___	___	Drugs/Alcohol use*	___	___	___	Thyroid Problem
___	___	___	Eczema	___	___	___	Tuberculosis
___	___	___	Emphysema	___	___	___	Sexually Trans. Disease
___	___	___	Headache	___	___	___	Others*

*Please specify

Family history

Please list ages, any illnesses, whether living or, if deceased, age at the time of death and cause.

Mother's side

Grandfather _____

Father's side

Grandfather _____

Grandmother _____

Grandmother _____

Please list name, age and state of health or any illnesses for:

Mother _____

Father _____

Sisters _____

Brothers _____

Children: _____

Other information you feel would be helpful for us to know about you.

Would you be interested in information about a document (It is called a *Durable Power of Attorney for Healthcare*) that allows you to state your preferences for healthcare in the event that you were unable to make decisions on your own? Y N

We thank you for taking the time in answering this questionnaire. It will help us to start to know you.