Indigo Integrative Health Clinic

"An ounce of prevention is worth a pound of cure." -Benjamin Franklin

Patient Name: **Date:**

DOB: **Age:** **Gender:** Female

Address:	
E-mail:	
SSN:	
Telephone Number:	(C): (H): Best time to reach you?
Marital Status:	○ Single ◉ Married ○ Divorced ○ Separated ○ Widowed ○ Minor ○ Partnered for _____ years
If minor, name of parent or guardian(s):	
If married, name of spouse:	
Occupation:	
Patient Employer / School:	
Employer/ School Address:	
Employer/ School Phone:	
IN CASE OF EMERGENCY:	Contact Name: Relationship: Telephone:
How did you hear about us?	☐ E-mail ☐ Flyer ☐ Facebook ☐ Twitter ☐ Newspaper ☐ Friend ☐ Online Ad ☐ Other_____
Do you have a primary care physician? If yes, please provide:	◉ Yes ○ No Name: Clinic Name: Telephone:
I understand and agree that (**regardless of my insurance status**), I am responsible for the balance on this account for any services, medications, or laboratory work, collection and/or attorney fees.	
Signature:	Date:_____

Name of Insurance Company:	
Who is responsible for this account?	Name: Relationship to patient: *(if different from patient)* SSN:
ID Number:	
Group Number:	
Is patient covered by additional insurance? ☐ Yes ☒ No	

HEALTH HISTORY

What is your most important health concern?
When did it begin?

Are you coming for any specific therapy?
(i.e. homeopathy, nutritional counseling, cupping, hydrotherapy)

This survey will help us to evaluate you more completely. Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. Include all the complaints which are familiar to you. If there are one or more words in a line which describe your specific problem you may want to circle those words.

NOW	PAST	GENERAL SYMPTOMS	NOW	PAST	GENERAL SYMPTOMS
		tired, weak, lack of energy			dizziness, fainting, convulsions
		depression, melancholy, moodiness			headaches
		worry, anxiety, nervousness, irritability			frequent colds or other illness
		don't sweat enough			sleeplessness or sleep to much
		sweat too much			loss or gain of weight
		night sweats			other:
NOW	PAST	EYES	NOW	PAST	EYES
		nearsightedness or farsightedness			blurred or failing vision
		dry, burning or itching eyes			eyes water excessively
		eyes sensitive to light			night blindness

		bloodshot or puffy eyes			other:
NOW	PAST	EARS	NOW	PAST	EARS
		earaches			noises or ringing in ears
		ear discharge			loss of hearing
		lots of wax			other:
NOW	PAST	NOSE AND THROAT	NOW	PAST	NOSE AND THROAT
		hay fever, sinusitis, runny nose			dry mouth or nose
		frequent nosebleeds			cracks in corners of mouth
		dry or chapped lips			sore throats or tonsilitis
		clear throat often			sore, red or cracked tongue
		cold sores or herpes			inability to smell or taste
		lots of cavities			bleeding gums
		hoarseness			other:
NOW	PAST	RESPIRATORY	NOW	PAST	RESPIRATORY
		frequent coughing			spitting up mucus or blood
		difficulty breathing, asthma			shortness of breath on exertion
		chest pain			other:
NOW	PAST	CARDIOVASCULAR	NOW	PAST	CARDIOVASCULAR
		heart beats fast or irregularly			tightness in chest
		discomfort at high altitude			dizzy or weak upon standing up
		swollen feet, ankles or legs			colds hands or feet
		hands or feet turn blue			blue fingernails
		leg pains when walking			varicose veins

		tendency to anemia			high blood pressure
		low blood pressure			other:
NOW	PAST	GASTROINTESTINAL	NOW	PAST	GASTROINTESTINAL
		loss of appetite			gagging, difficulty swallowing
		nausea or vomiting			bad breath
		metallic or bitter taste in mouth			food cravings or strong desires
		can't eat fats			heartburn
		indigestion or distress			heaviness after eating
		belching or gas			bloating
		stomach or abdomen tender or painful			symptoms relieved by eating
		symptoms worse after eating			avoid certain foods
		headache, dizziness or irritability if skip meal			diarrhea or loose stool
		constipation			change in bowel movements
		light colored or greasy stools			dark stools or blood in stool
		feeling of incomplete evacuation			undigested food in stool
		foul odor of stool or gas			hemorrhoids
		other:			
NOW	PAST	URINARY	NOW	PAST	URINARY
		difficulty urinating			urinate frequently at night
		bedwetting			incomplete urination or dribbling
		pain when urinating			bladder infections
		kidney infections			kidney stones
		lower back pain			other:

NOW	PAST	MALE	NOW	PAST	MALE
		prostate problems			difficult or unusual urination
		discomfort or pain in genital area			diminished sexual desire
		excessive sexual desire			difficulty maintaining an erection
		other:			
		Last date of DRE: PSA: History of STD's:			
NOW	PAST	FEMALE	NOW	PAST	FEMALE
		irregular menstruation			pain prior to or with periods
		depressed, tense or irritable around periods			painful or swollen breasts
		lumps in breasts			discharge from breasts
		symptoms occur in monthly pattern			pain, discomfort or itching in genital area
		vaginal discharge			hot flashes
		diminished sexual desire			excessive sexual desire
		difficulty having orgasm			inability to conceive
		pregnancies, number:			children, number:
		miscarriages or abortions			other:
NOW	PAST	MUSCULOSKELETAL	NOW	PAST	MUSCULOSKELETAL
		muscle plain or stiffness where?			swollen, painful or stiff joints
		bone pains			painful feet, ankles or calves
		tremors or twitches			loss of strength
		hernia			muscle wasting
		other:			

NOW	PAST	SKIN AND HAIR	NOW	PAST	SKIN AND HAIR
		acne or pimples			skin rashes
		hives			stretch marks
		skin ulcers or sores			dryness, roughness or scaling skin, scalp, elbows, knees, feet, around nose, ears, eyebrows, etc.
		hair loss or thinning			dry, coarse hair or split ends
		bruise easily			nails weak, ridged or split easily
		brown spots or bronzing on skin			moles, warts or skin tags
		sunburn easily			cuts heal slowly or scar badly
		flush easily			hands or feet numb or tingling
		feet burn			athletes foot
		other:			

FEMALES	
Date of last menstrual period:	Number of days _____ Length of cycle _____
Date of last PAP smear:	Have you ever had an abnormal PAP?
Present type of birth control:	Have you ever used birth control pills or an IUD? YES What type and for how long?
Last mammogram:	
History of STD's:	

General Energy:											
Scale how energetic you feel, 10 being the most energetic.	0	1	2	3	4	5	6	7	8	9	10

Sleep:	Time fall asleep _____ Time wake up _____
Hospitalizations or Surgeries:	
Please list any recent labwork and abnormal findings if any:	
What diagnostic imaging studies have you had? Please provide date of imaging.	☐ Bone density scan _____ ☐ X-rays_____ ☐ Electrocardiogram_____ ☐ CT scan_____ ☐ Electroencephalogram_____ ☐ MRI_____ ☐ Ultrasound_____ ☐ Colonoscopy/Sigmoidoscopy_____ ☐ Other:
Please list last dental and eye exams:	Dental: Eye:

Medications & Supplements

Do you take or use any of the following:

☐ Pain relievers (aspirin, ibuprofen) ☐ Sleeping pills ☐ Tranquilizers
☐ Diet pills, appetite suppressants ☐ Antibiotics ☐ Laxatives
☐ Thyroid medication ☐ Antacids ☐ Cortisone (cream or pills)

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking with brand names and dosages:

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Is your **DIET**:

☐ Typical American ☐ Vegetarian ☐ Vegan ☐ Fast food
☐ Kosher ☐ Macrobiotic ☐ Low fat ☐ Other:

Do you get regular exercise? Please list what and how often.

Do you use any of the following?

☐ Cigarettes or tobacco _____ packs per day ☐ Coffee _____ cups per day
☐ Marijuana or other drugs _____ times per week ☐ Alcohol _____ times per day/week

ALLERGIES: Are you allergic to anything? Include food, plants, medications, pollens, insects, MSG, chemicals, etc.

<u>Have you or any of your family members had any of the problems in this chart?</u> Please indicate who has had which problems by checking the appropriate space.

	Thyroid problems	Diabetes	Tuberculosis	Hypoglycemia	Stroke	Heart Attack	Epilepsy	Cancer	Asthma	Allergies	Anemia	Migraines	Hepatitis	Heart disease	Birth Defects	High Blood Pressure	Gall Bladder Disease	Arthritis	Alcoholism/addictions
Self																			
Children																			
Mother																			
Father																			
Sister(s)																			
Brother(s)																			
Grandparents																			
Others																			

Thank you for taking the time to fill out this questionnaire. For additional comments, please use the other side.

PRINT