



INTEGRATIVE MENTAL HEALTH
CENTER

Date: _____

Patient Name: _____
Age: _____ Date of Birth: _____ Height: _____ Weight: _____
Gender: Female Male Marital Status: _____ If married, #years: _____ #Children: _____
Occupation: _____ Employer: _____
Highest level of education: _____

Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ E-mail: _____

Person to Contact in Case of Emergency: _____
Relationship to Patient: _____
Phone: _____

How Did You Hear About Us?
 Yellow Pages Other Practitioner Who? _____
 Internet Search Current Patient Who? _____
 Our Website Other _____

Insurance Company: _____ PPO HMO
Primary Care Doctor: _____
Pharmacy # (if use specific pharmacy regularly): _____

If patient is a Minor, Name of Parent/Guardian(s)

HEALTH CONCERNS

Please list your current health concerns in order from most bothersome to least bothersome. Please include mental, emotional, and physical concerns.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES

Date	Condition or Procedure
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

MEDICATIONS

Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.

Medication	Condition Treated	Dosage
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____

SUPPLEMENTS

Please list all of the supplements that you are currently taking including dosages and brand names.

Supplement	Dosage	Brand
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOW PAST GENERAL SYMPTOMS

		Tired, weak, lack of energy
		Depression, moodiness
		Worry, anxiety, nervousness
		Sleeplessness or too much sleep
		Frequent colds or other illnesses
		Headaches, migraines
		Dizziness, fainting, blacking out
		Cannot sweat/ too much sweat/ night sweats

NOW PAST EYES

		Nearsightedness or farsightedness
		Blurred or failing vision
		Dry, burning or itching eyes
		Eyes water excessively
		Night blindness
		Bloodshot, red or puffy eyes
		Mucus or discharge in eyes
		Pain in eyes

NOW PAST EARS

		Earaches
		Noises or ringing in ears
		Ear discharges
		Loss of hearing
		Excess earwax
		Difficulty hearing

NOW PAST CHEST

		Cough frequently
		Spitting up mucous or blood
		Difficultly breathing
		Chest pain
		Wheezing
		Palpitations

NOW PAST SKIN & HAIR

		Acne or pimples
		Hives, rashes
		Stretch marks
		Skin ulcers or sores
		Dryness, roughness or scaling skin
		Hair loss or thinning
		Dry, course hair
		Bruise easily
		Nails weak, ridged or split easily
		Brown spots or bronzing on skin
		Warts, moles or skin tags
		Sunburn easily
		Cuts heal slowly or scar badly
		Flush easily
		Athletes foot

NOW PAST NOSE & THROAT

		Allergies, sinusitis, runny nose
		Dry mouth or nose
		Nosebleeds
		Cracks in corners of mouth
		Dry or chapped lips
		Sore throats or tonsillitis
		Sore, red, or cracked tongue
		Cold sores or herpes
		Loss of smell or taste
		Bleeding gums
		Hoarseness
		Grinding teeth
		Dental problems
		Difficulty swallowing

NOW PAST GASTROINTESTINAL

		Loss of appetite
		Nausea or vomiting
		Bad breath
		Metallic or bitter taste in mouth
		Heartburn
		Indigestion
		Heaviness after eating
		Bloating or gas
		Belching
		Constipation
		Foul odor of stool or gas
		Diarrhea
		Light colored or greasy stools
		Undigested food in stool
		Blood in stool or on paper
		Hemorrhoids
		Rectal pain/itching

NOW PAST CARDIOVASCULAR

		Heart beats fast or irregularly
		Tightness in chest
		Discomfort in high altitude
		Dizzy or weak on standing
		Swollen feet, ankles or legs
		Cold hands or feet
		Hands or feet turn blue
		Leg pain with walking
		High blood pressure
		Low blood pressure

NOW PAST MUSCULOSKELETAL

		Muscle pain
		Weakness
		Joint pain (specify: _____)
		Joint swelling
		Back pain
		Neck pain
		Joint stiffness
		Numbness or tingling
		Decreased range of motion

NOW PAST FEMALE

		Irregular periods
		Pain prior to or with periods
		Depressed or irritable around periods
		Painful or swollen breasts
		Lumps in breast
		Nipple discharge
		Vaginal discharge
		Vaginal pain or itching
		Heavy periods
		Hot flashes
		Diminished or excessive sex drive
		Difficulty reaching orgasm
		Miscarriages (How many? _____)
		Abortions (How many? _____)
		Pain with intercourse
		Pelvic pain
		Inability to conceive

NOW PAST MALE

		Prostate problems
		Sexual difficulty
		Genital discharge
		Rashes or sores
		Pain in genitals
		Painful testicles
		Prostate problems

NOW PAST URINARY

		Difficulty urinating
		Urinate frequently at night
		Bed Wetting
		Incomplete urination or dribbling
		Pain when urinating
		Bladder or kidney infection
		Kidney stones
		Urine leakage
		Blood in urine

PAST MEDICAL CONDITIONS

Please check any conditions in your history:

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Psoriasis/Eczema
<input type="checkbox"/>	Alcoholism/Addiction	<input type="checkbox"/>	Depression/Anxiety/Bipolar	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	Psychiatric Hospitalization
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Sexual Abuse
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Suicide Attempt
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Thyroid Condition
<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Physical Abuse	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer: _____	<input type="checkbox"/>	Herpes (Oral / Genital)	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Vaginal Infections
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Venereal Disease

Check whether you have had the following screening tests, and whether they have been abnormal:

Screening Test	Anything Abnormal?	Frequency of Screening	Last Test/Exam
General screening blood tests			
General physical exam			
Mammogram/breast imaging			
Colonoscopy			
Women's wellness exam			
Bone density test			
Prostate exam			

I certify that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____