

Center for Integral Health

INFORMATION FOR YOUR PHYSICIAN

Referred by: _____

Today's Date: _____

Name: _____	Age: _____	Date of Birth: _____
Address: _____		
Street	City	State Zip
Home Phone: () _____	Work Phone: () _____	
Marital Status: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	No. of Children: _____	SS#: _____
Present Marriage: (yr. married) _____	Previous Marriage: (yr. & duration) _____	
Occupation: _____	How Long: _____	Employer: _____
Education: (Highest Level Attained) _____		

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:

COMPLAINT	SINCE	CAUSE

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	SINCE	ADVERSE EFFECTS

List Any Allergies: _____

HAVE YOU TAKEN CORTISONE TYPE DRUGS? YES or NO BIRTH CONTROL PILLS? YES or NO

HAVE YOU HAD A TRANSFUSION? YES or NO IF YES, GIVE DATE: _____

WHAT OTHER TREATMENT/REGIMES ARE YOU CURRENTLY FOLLOWING?

TREATMENT/REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

Abscesses	Alcoholism	Allergies	Anemia	Arthritis
Asthma	Bleeding	Cancer	Chicken Pox	Cold Sores
Depression	Diabetes	Emphysema	Epilepsy	Gall stones
Goiter	Gonorrhea	Gout	Hay Fever	Heart Disease
Hepatitis	Herpes	Jaundice	Influenza	Kidney Disease
Leukemia	Malaria	Measles	Miscarriage	Mono
Mumps	Parasites	Peritonitis	Pleurisy	Pneumonia
Prostatitis	Rheumatic Fever	Rubella	Scarlet Fever	Sexual Abuse
Skin Disease	Strep Throat	Sinusitis	Stroke	Sunstroke
Syphilis	Tonsillitis	Tuberculosis	Typhoid Fever	Venereal Warts
Warts	Whooping Cough	Worms	Yellow Fever	
Pelvic Inflammatory Disease				

ANY OTHER MAJOR CONDITIONS? _____

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Which ones? _____

 "I, _____ have received a copy of *The Center for Integral Health's Notice or Privacy*
Practices. Signature (Parents signature-on peds form) _____ Date _____

WHAT OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATIONS

WHAT MAJOR INJURIES HAVE YOU HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS

Age of First Menses: _____ First Day of Last Menses: _____ Menses are regular: Yes No

Number of Pregnancies: _____ Number of Miscarriages: _____

What immunizations have you had? _____

Any adverse effects from them? _____

Any prolonged courses of antibiotics? _____ Why? _____ Any adverse effects? _____

Have you lost weight lately? _____ How many pounds? _____ Present weight: _____

What exercise do you do and how much? _____

Any dental problems now? _____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

TOBACCO	ALCOHOL
COFFEE	TEA
	RECREATIONAL DRUGS

INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS OR ANY OTHER MAJOR AILMENTS, HAVE AFFECTED YOUR BLOOD RELATIVES

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression
Diabetes	Epilepsy	Gonorrhoea	Gout	Hay Fever	Heart Disease
Insanity	Paralysis	Pneumonia	Skin Disease	Syphilis	Tuberculosis

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

PHYSICIAN	FOR WHAT CONDITIONS?	TREATMENT?

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

PHYSICIAN	FOR WHAT CONDITIONS?	WHEN?