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 ☐ M ☐ D ☐ W ☐ 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		Gonorrhea		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?