



# Integrated Center for Optimum Health, LLC

(Confidential)

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

What problem are you here for today? \_\_\_\_\_

Have you been given a diagnosis for this problem by your family physician? \_\_\_\_\_

Mark on the scale below your **present injury** function. (Please circle)

1 %-----10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Please describe below the area of your **discomfort / pain location**.

**Pain information.**

_____		Yes	No
_____			
_____	Throbbing	<input type="checkbox"/>	<input type="checkbox"/>
_____	Sharp	<input type="checkbox"/>	<input type="checkbox"/>
_____	Aching	<input type="checkbox"/>	<input type="checkbox"/>
_____	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
_____	Burning	<input type="checkbox"/>	<input type="checkbox"/>
_____	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
_____	Shooting	<input type="checkbox"/>	<input type="checkbox"/>

**Rate your current pain intensity (Please circle)**

0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

Which activities increase your symptoms?

- Sitting
- Walking
- Driving
- Kneeling
- Twisting
- Standing
- Reaching
- Reclining
- Lifting
- Bending
- Squatting
- Stairs
- Rising
- Other: \_\_\_\_\_

What eases your symptoms?

- Moist heat
- Ice application
- Medication
- Rest
- Change in position
- Other: \_\_\_\_\_

Is your condition overall:

- Improving
- Getting worse
- Staying the same

Have you had any treatment for this current problem in the past?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you received any of the following tests for this problem?

- X-rays
- CT scan
- Bone scan
- EMG
- Nerve conduction study
- MRI
- Other: \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Describe how/when your problem occurred:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*How would you describe your overall health?*

- Poor       Fair       Good       Excellent

*What is your present:*      Height \_\_\_\_\_      Weight \_\_\_\_\_ lbs.

*Have you had a similar problem previously?*       Yes       No

Specifics: \_\_\_\_\_

**Have you received any surgeries in the past?**       Yes       No

If yes, please describe: \_\_\_\_\_

*Have you had any long-term use of Prednison, cortisone, steroids, or inhalants?*       Yes       No

If, yes, please specify: \_\_\_\_\_

*Are you currently taking any herbs or vitamins?*       Yes       No

If, yes, please describe: \_\_\_\_\_

**Are you able to continue working?**       Yes       No

If no, when did you last work? \_\_\_\_\_

*Are the physical demands of your job?*       Light       Moderate       Heavy

*Are you able to continue your recreational or sporting activities?*       Yes       No

Specifics: \_\_\_\_\_

**Average Daily Diet:**

*Breakfast:* \_\_\_\_\_

*Lunch:* \_\_\_\_\_

*Dinner:* \_\_\_\_\_

**What are your goals and expectations for treatment?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Patient's Name: \_\_\_\_\_

Today's date: \_\_\_\_\_

**Please answer all questions in reference to your current status.**

Are you currently working?

<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
<input type="checkbox"/>	<b>Part-time</b>	<input type="checkbox"/>	<b>Full-time</b>

Are you able to continue your recreational and sports activities?

<input type="checkbox"/>	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>
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<b>Current Pain Scale Rating (circle)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Maximum Functional Capacity Rating</b>	<b>10%</b>	<b>20%</b>	<b>30%</b>	<b>40%</b>	<b>50%</b>	<b>60%</b>	<b>70%</b>	<b>80%</b>	<b>90%</b>	<b>100%</b>	
<b>Please Mark the most appropriate answer to your current status:</b>											
	<b>I can not!</b>	<b>Less than 5 minutes</b>	<b>Less than 15 minutes</b>	<b>Less than 45 minutes</b>	<b>Between 1-2 hours</b>	<b>More then 2 hours</b>					
How long can you sit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
How long can you stand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
How long can you walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
	<b>I can not!</b>	<b>Less than 5 lbs.</b>	<b>Less than 15 lbs.</b>	<b>Less than 25 lbs.</b>	<b>Between 25-60 lbs.</b>	<b>More then 60 lbs.</b>					
How much can you lift/carry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Please mark the most appropriate answer to your current status:**

<b>Sleep:</b>	Can't fall asleep. <input type="checkbox"/>	Awaken at night. <input type="checkbox"/>	Not rested in the morning. <input type="checkbox"/>	Sleep disturbing dreams. <input type="checkbox"/>	
<b>Temperature:</b>	Cold hands and/or feet. <input type="checkbox"/>	Chills. <input type="checkbox"/>	Fever. <input type="checkbox"/>	Too warm or too cold. <input type="checkbox"/>	Normal. <input type="checkbox"/>
<b>Stools/Urine:</b>	Pain and/or blood. <input type="checkbox"/>	Constipation. <input type="checkbox"/>	Diarrhea. <input type="checkbox"/>	Loose Stool. <input type="checkbox"/>	Normal. <input type="checkbox"/>
<b>Sweating:</b>	Excessive. <input type="checkbox"/>	Night Sweat. <input type="checkbox"/>	Normal. <input type="checkbox"/>		
<b>Headaches:</b>	No. <input type="checkbox"/>	Yes. <input type="checkbox"/>	If yes: Time of day: _____	Dizziness. <input type="checkbox"/>	
<b>Thorax/Abdomen:</b>	Pain. <input type="checkbox"/>	Palpitations. <input type="checkbox"/>	Difficulty Breathing <input type="checkbox"/>		
<b>Appetite:</b>	Excessive. <input type="checkbox"/>	Decreased. <input type="checkbox"/>	Cravings. <input type="checkbox"/>	Vomiting. <input type="checkbox"/>	
<b>Digestion:</b>	Gas. <input type="checkbox"/>	Bloating. <input type="checkbox"/>	Distension. <input type="checkbox"/>	Pain. <input type="checkbox"/>	
<b>Thirst:</b>	Decreased. <input type="checkbox"/>	Increased. <input type="checkbox"/>	Preference for cold drinks. <input type="checkbox"/>	Preference for warm drinks. <input type="checkbox"/>	
<b>Women only:</b>	Day of cycle: _____	PMS. <input type="checkbox"/>	Pregnant. <input type="checkbox"/>		
Please describe any difficulties or problems with regards to your ears, nose, eyes and throat:		_____			
What treatment other than acupuncture do you receive?		_____			
List all your current medications:		_____			
<b>Please describe all other limitations:</b>		_____			

**\*Confidential Health History\***

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of Last Physical Examination \_\_\_\_\_  
 What is the reason for your visit? \_\_\_\_\_

**\*Symptoms\***

Check (✓) conditions you currently have or have had in the past year.

**General**

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

**Muscle/Joint/ Bone**

Pain, weakness, numbness in:

- Arms       Hips
- Back       Legs
- Feet       Neck
- Hands       Shoulders

**Genito-Urinary**

- Blood in Urine
- Frequent urination
- Lack of bladder control
- Painful urination

**Gastrointestinal**

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

**Cardiovascular**

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling ankles
- Varicose veins

**Eye, Ear, Nose, Throat**

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

**Skin**

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

**MEN only**

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

**WOMEN only**

- Abnormal Pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period: \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_

Have you had A mammogram? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Number of children \_\_\_\_\_

**\*Symptoms\***

Check (✓) conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Live Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid problem
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

**\*Medications\*** List medications that you are currently taking

**\*Allergies\***

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*Family History\***

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following	
					✓ Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

**\*Hospitalizations**

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion?  Yes  No

If yes, please give approximate dates: \_\_\_\_\_

Serious Illness/Injuries	Date	Outcome

**\*Pregnancies\***

**\*Health Habits\***

**\*Occupational\***

Year of Birth	Sex of Birth	Complications, if any	Check (✓) which substances you use and describe how much you use		Check (✓) if your work exposes you to the following:	
			Caffeine		Stress	
			Tobacco		Heavy Lifting	
			Drugs		Hazardous Substances	
			Other		Other	

Occupation: \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor/therapist or any members of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Reviewed By

\_\_\_\_\_ Date