ARIA INTEGRATIVE MEDICINE

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# Patient Health Information Form

Last Name: ______________________________ First Name: ______________________________

Nickname: __________________ Birthdate: ______/______/______ Sex (specify):______________

Please complete this questionnaire as thoroughly as possible **before your 1st visit**. This will help us to better assist you in treatment for your condition. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so.

| PRESENT HEALTH CONCERNS | |
|---|---|
| **Please list the most important health concerns in order of significance** | **Prior diagnosis of this problem (if one has been made)** |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

What are your goals for treatment with our clinic? ________________________________________

______________________________________________________________________________

Where would you say your health is currently? (Check One)

1 2 3 4 5 6 7 8 9 10

Extremely Poor Extremely Well

| MEDICATIONS AND SUPPLEMENTS | | |
|---|---|---|
| Please list the **medications** that you are currently taking with dosages and who prescribed them: | | |
| **Medication (Name)** | **Dosage (amount, time(s) per day)** | **Prescriber (Doctor name/self)** |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| **If you need additional room, please attach an updated medication list to this form* | | |

| Please list all the **supplements** that you are currently taking with dosages and who prescribed them: | | |
|---|---|---|
| **Supplement (Brand, Name)** | **Dosage (amount, time(s) per day)** | **Prescriber (Doctor name/self)** |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| **If you need additional room, please attach an updated supplement list to this form* | | |

## ALLERGIES

Do you have any LIFE-THREATENING allergies to medications or anything else? ☐ Yes ☐ No

If Yes, please explain: ____________________________________________

____________________________________________

Do you have any NON Life-threatening allergies or medications or anything else? ☐ Yes ☐ No

If Yes, please explain: ____________________________________________

____________________________________________

## SOCIAL HISTORY

Do you use any of the following substances regularly? How often?

- ☐ Tobacco ______________________
- ☐ Alcohol ______________________
- ☐ Coffee/Black Tea/Cola ______________________
- ☐ Recreational Drugs ______________________

Do you follow any diet regimens or restrictions (Vegetarian, Vegan, Gluten Free...etc.)? ☐ Yes ☐ No

If Yes, please describe: ____________________________________________

Do you exercise regularly? ☐ Yes ☐ No How often? ______________________

What Type? ______________________________

How Long? ______________________________

| PAST MEDICAL HISTORY | |
|---|---|
| Have you had any of the following: | |
| **Hospitalizations:** | **What Month/Year:** |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| **Serious Illness/Injury:** | **What Month/Year:** |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

Date of last physical exam: ______________________

What exams were done at that time? _________________________________________________________

_____________________________________________________________________________________

Date of last blood tests: _________________________

What tests were done at that time? __________________________________________________________

_____________________________________________________________________________________

**PERSONAL AND FAMILY HISTORY**

If any of the following conditions applies **to you** or one of your **immediate** family members (parents, siblings, grandparents), please note the person associated with the condition, what year the condition took place and whether or not the condition is current.

| Condition | Person Affected (Self, Parent… etc.) | Year | Current? |
|---|---|---|---|
| Addiction (including alcoholism) | | | |
| Allergies (specify) | | | |
| Anemia | | | |
| Arthritis (specify) | | | |
| Asthma | | | |
| Cancer (specify) | | | |
| Celiac Disease | | | |
| Crohn's Disease | | | |

| PERSONAL AND FAMILY HISTORY (CONT) | | | |
|---|---|---|---|
| **Condition** | **Person Affected** | **Year** | **Current?** |
| Depression | | | |
| Diabetes | | | |
| Eczema | | | |
| Epilepsy | | | |
| Headaches | | | |
| Heart Disease (specify) | | | |
| Hepatitis | | | |
| High Blood Pressure | | | |
| Kidney Disease (specify) | | | |
| Lupus (specify) | | | |
| Mental Illness (specify) | | | |
| Multiple Sclerosis | | | |
| STD (specify) | | | |
| Stroke | | | |
| Thyroid Disorder (specify) | | | |
| Tuberculosis | | | |
| Ulcerative Colitis | | | |
| Other | | | |

What is your marital Status? (Circle One) Single Married Significant Other

Do you have any children? □ Yes □ No How Many: ______________________________

Number of living children: ________________ Ages: ______________________________

Are you currently employed? □ Yes □ No If yes, then where? ______________________

How long have you been employed here: _______________ Do you enjoy your work? ____________

What do you do for fun? ______________________________________________________

**For Admin Use Only**

Provider reviewed with patient. Signature: ______________________________ Date: _______________