

# PATIENT CONFIDENTIAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First Middle Last

Name that you prefer: \_\_\_\_\_ Marital: M S D W Male \_\_\_\_\_ Female \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_ Lv. Msg? Y N Cell: \_\_\_\_\_ Lv. Msg? Y N

Work: \_\_\_\_\_ Lv. Msg? Y N Fax: \_\_\_\_\_ Email: \_\_\_\_\_

## Home Address:

Street City State Zip

Referred By: \_\_\_\_\_

Current Medical Condition(s)? \_\_\_\_\_

Medication(s) /Supplement(s) you are currently taking? \_\_\_\_\_

Are you Sensitive /Allergic to any Medication, Supplements, or Anesthesia Materials? \_\_\_\_\_

## Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone : \_\_\_\_\_ Cell : \_\_\_\_\_ Work : \_\_\_\_\_

## Spousal Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer/Employer Phone : \_\_\_\_\_

## For Minors:

List both parents' names, phone numbers, and addresses

1) \_\_\_\_\_  
2) \_\_\_\_\_

Initial \_\_\_\_\_ **CANCELLATION/RESCHEDULE POLICY:** Arizona Integrative Medical Center, P.C. has a 24-hour cancellation/reschedule policy. If you miss your office or lab appointment or do not contact us to reschedule within 24 hours prior to your scheduled appointment, you will be charged a \$50.00 cancellation fee.

Initial \_\_\_\_\_ **FEE/RETURN POLICY:** To help control costs, we ask our patients to pay for visits/procedure/supplements/lab work and any treatment at the time services are rendered. We cannot render services on the assumption that our fees will be paid by an insurance company. Returned checks will incur a \$35 fee. Any overdue accounts will be referred to a collection agency. Supplements cannot be returned, for any reason even if unopened, due to safety and sanitation .

Initial \_\_\_\_\_ **ESTIMATES:** Any estimates of anticipated fees, for budgeting purposes or otherwise, are, due to the uncertainties involved, only approximation of potential fees Under no circumstances are such estimates a maximum or minimum fee quotation. Our actual fees will be determined in accordance with this Agreement.

*By signing below, I have read and fully understand the Cancellation/Reschedule Policy and Fee Policy, and I understand and agree that I am responsible for the balance on this account and guarantee payment of all charges incurred as a patient of Arizona Integrative Medical Center, P.C. and Paul Stallone, N.M.D. regardless of any insurance companies' determination of benefits.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_

Parent or Guardian (for minor) \_\_\_\_\_

**ARIZONA INTEGRATIVE MEDICAL CENTER, P.C.**

8144 E. Cactus Rd. Ste # 820

Scottsdale, AZ 85260

Phone: (480) 214-3922

Fax: (480) 214-3922

**Patient Intake Form**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**List in order of importance what your problems are:**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**Date of last blood work performed and by which physician:** \_\_\_\_\_

**Family History**

	Father	Mother	Siblings	Spouse	Grandparents	Children
Age (if living):	_____	_____	_____	_____	_____	_____
Age (if passed):	_____	_____	_____	_____	_____	_____
Reason for Death:	_____	_____	_____	_____	_____	_____
Cancer Type:	_____	_____	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

**List All Surgeries & Hospitalization, including date occurred:**

- 1) \_\_\_\_\_ 4) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_

**Please note when and why you have had each of the following performed:**

X-Rays: \_\_\_\_\_ MRI/Cat Scans: \_\_\_\_\_

Ultrasounds: \_\_\_\_\_ Accidents: \_\_\_\_\_

TB Test: \_\_\_\_\_ HCV: \_\_\_\_\_

HIV: \_\_\_\_\_ Last Dental Visit: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_

Did you have the following:  
**Disease (D), Immunized (I), or Neither (N)**

**Measles:** D I N      **Chicken Pox:** D I N      **Mumps:** D I N      **Rubella:** D I N  
**Tetanus:** D I N      **Whooping Cough:** D I N      **Hemophilus (Hib):** D I N      **Hebatitis B:** D I N  
**German Measles:** D I N      **Any vaccination reactions:** \_\_\_\_\_

List **Yes (Y), No (N), or Past (P)** regarding use of the following:

**Ant-acids:** Y N P    **Steroids:** Y N P    **Smoking:** Y N P **Packs per day & numbers of years:** \_\_\_\_\_  
**Analgesics:** Y N P    **Laxatives:** Y N P    **Coffee:** Y N P    **Cups per day:** \_\_\_\_\_  
**Soda Pop:** Y N P    **Ounces per day:** \_\_\_\_\_    **Alcohol:** Y N P    **How often & how much:** \_\_\_\_\_  
**Any Alcohol Addiction:** Y N P    **Any Alcohol Treatment:** Y N P  
**Recreational Drugs:** Y N P      **Any Drug Addictions:** Y N P    **Any Drug Treatment:** Y N P

List all **Prescription Medicines and Nutrient Supplements/Herbs** you are currently taking and dosage:

### Review of System:

**Present Weight:** \_\_\_\_\_    **Weight one year ago:** \_\_\_\_\_    **Height:** \_\_\_\_\_  
**Maximum weight and when:** \_\_\_\_\_    **Minimum weight and when (as adult):** \_\_\_\_\_  
**Ideal weight:** \_\_\_\_\_

Regarding the next section: Please circle **(Y)** if you have a symptom **NOW**, **(N)** if you've **NEVER** had the symptom, and **(P)** if you had the symptom in the **PAST**.

**Good Energy:** Y N P    **Fatigue:** Y N P  
**If you have fatigue, when in morning, afternoon, evening is it the worst?** \_\_\_\_\_  
**If you have fatigue, can you do what you need to during the day?**    Y    N

<u>Skin</u>				
<b>Rash:</b>	Y N P		<b>Color Change:</b>	Y N P
<b>Hives:</b>	Y N P		<b>Lump:</b>	Y N P
<b>Psoriasis/Eczema:</b>	Y N P		<b>Itchy Skin:</b>	Y N P
<b>Dry Skin:</b>	Y N P		<b>Warts/Moles:</b>	Y N P
<b>Skin Cancer:</b>	Y N P		<b>Perspiration:</b>	Y N P
<u>Head</u>				
<b>Headache:</b>	Y N P		<b>Migraine:</b>	Y N P
<b>Dandruff:</b>	Y N P		<b>Head Injury:</b>	Y N P
<b>Oil/Dry Hair:</b>	Y N P		<b>Hair Loss:</b>	Y N P

<u>Nose</u>				
Frequent Colds:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Post Nasal Drip:	Y N P
Polyps:	Y N P		Seasonal Allergies:	Y N P
<u>Eyes</u>				
Dry/Watery:	Y N P		Blurry Vision:	Y N P
Double Vision:	Y N P		Cataracts:	Y N P
Glaucoma:	Y N P		Styes:	Y N P
Strain:	Y N P		Discharge:	Y N P
Itchy:	Y N P		Dark under Eye:	Y N P
<u>Mouth/Throat</u>				
Canker Sores:	Y N P		Cold Sores:	Y N P
Sore Throat:	Y N P		Gum Disease:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Loss of Taste:	Y N P		Hoarseness:	Y N P
<u>Neck</u>				
Stiffness:	Y N P		Swollen Glands:	Y N P
Full Movement:	Y N P		Tension:	Y N P
<u>Respiratory</u>				
Cough:	Y N P		TB:	Y N P
Shortness of Breath (w/exertion):	Y N P		Bronchitis:	Y N P
Shortness of Breath (sitting):	Y N P		Pneumonia:	Y N P
Shortness of Breath (lying down):	Y N P		Asthma:	Y N P
Wheezing:	Y N P		Painful Breathing:	Y N P
<u>Cardiovascular</u>				
High Blood Pressure:	Y N P		Rheumatic Fever:	Y N P
Low Blood Pressure:	Y N P		Murmurs:	Y N P
Arrhythmias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Chest Pains:	Y N P

<u>Urinary Tract</u>				
Incontinence:	Y N P		Pain w/ Urination:	Y N P
Frequent Infections:	Y N P		Kidney Stones:	Y N P
Urgency:	Y N P		Discharge/Blood:	Y N P
<u>Gastrointestinal</u>				
Heartburn:	Y N P		Bowel Movements Per Day: _____	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/ Constipation	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease:	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer:	Y N P
<u>Male Genitalia</u>				
Testicular Pain/ Swelling	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.'s:	Y N P
Discharge:	Y N P		Prostate Disease/ Symptoms	Y N P
Impotency:	Y N P		Sexual Orientation:	Hetero Homo Bi
Last Prostate Exam:			Prostate Exam Results:	
<u>Female Genitalia</u>				
Age of 1st Period:			Period Occurs How Often:	
Length of Periods:			Heavy Menstrual Bleeding:	Y N P
# of Births:			Menstrual Pain:	Y N P
# of Abortions:			Food Cravings:	Y N P
# of Pregnancies:			Dexa Scan:	Y N P
# of Miscarriages:			PMS:	Y N P
Last Pap Smear:			Healthy Libido:	Y N P
-Diagnosis:			Sexually Active:	Y N P
Any Abnormal Paps:	Y N P		Vaginitis:	Y N P
-When:			S.T.D.'s:	Y N P
Menopausal since age:			Pain w/Intercourse:	Y N P
Use of Hormones:	Y N P		Dry Vagina:	Y N P
Type of Hormones Used:			Mammography:	Y N P
Menstrual Cramping:	Y N P		-What were results	

Please list any birth control used and state age when method was used: \_\_\_\_\_

<u>Musculoskeletal</u>				
<b>Weakness:</b>	<b>Y N P</b>		<b>Arthritis:</b>	<b>Y N P</b>
<b>Stiffness:</b>	<b>Y N P</b>		<b>Leg Cramps:</b>	<b>Y N P</b>
<b>Tremors:</b>	<b>Y N P</b>		<b>Pain:</b>	<b>Y N P</b>
<u>Nervous</u>				
<b>Paralysis:</b>	<b>Y N P</b>		<b>Sciatica:</b>	<b>Y N P</b>
<b>Tingling/ Numbness:</b>	<b>Y N P</b>		<b>Carpal Tunnel Syndrome:</b>	<b>Y N P</b>
<b>Seizures:</b>	<b>Y N P</b>		<b>Fainting:</b>	<b>Y N P</b>
<u>Mental/Emotional</u>				
<b>Depression:</b>	<b>Y N P</b>		<b>Anger/Irritability:</b>	<b>Y N P</b>
<b>Suicidal:</b>	<b>Y N P</b>		<b>High-Strung/Tense:</b>	<b>Y N P</b>
<b>Anxiety:</b>	<b>Y N P</b>		<b>Fear/Panic:</b>	<b>Y N P</b>
<b>Eating Disorder:</b>	<b>Y N P</b>		<b>Psych Hospitalization:</b>	<b>Y N P</b>

### Exercise

How often do you exercise? \_\_\_\_\_ What type of exercise? \_\_\_\_\_  
 For how long? \_\_\_\_\_ Hobbies: \_\_\_\_\_

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### Sleep

How many hours per night? \_\_\_\_\_ If you wake up frequently, what is the reason? \_\_\_\_\_

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<b>Nightmares:</b>	Y N P	<b>Wake Refreshed:</b>	Y N P	<b>Must nap during day:</b>	Y N P
<b>Sleep Walk:</b>	Y N P	<b>Grind Teeth:</b>	Y N P	<b>Snore</b>	Y N P

### Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution were you exposed to? \_\_\_\_\_

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Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic material? If so, please list: \_\_\_\_\_

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Have you ever had health problems when you put in new carpet, painted your home, had new cabinets or did other refurbishing? If so, please list: \_\_\_\_\_

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Are you particularly sensitive to perfumes, gasoline or other vapors? If so, please list: \_\_\_\_\_

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Do you use pesticides, herbicides, or other chemicals around your home? If so, please list: \_\_\_\_\_

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### Social Life

Hours worked per week: \_\_\_\_\_ Highest level of education: \_\_\_\_\_  
 What is your greatest health concern and how does it limit you? \_\_\_\_\_

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<b>Enjoy Job:</b>	Y N P	<b>How committed are you towards making valuable changes?</b>	Little	Moderately	Very
<b>Active Spiritual Practice:</b>	Y N P	<b>History of Sexual, Mental/ Emotional, Physical Abuse? If so, please state age and by whom:</b>			