

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.

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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>				
Rash:	Y N P		Color Change:	Y N P
Hives:	Y N P		Lump:	Y N P
Psoriasis/Eczema:	Y N P		Itchy Skin:	Y N P
Dry Skin:	Y N P		Warts/Moles:	Y N P
Skin Cancer:	Y N P		Perspiration:	Y N P
<u>Head</u>				
Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oil/Dry Hair:	Y N P		Hair Loss:	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 G L T 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>				
Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P
<u>Nervous</u>				
Paralysis:	Y N P		Sciatica:	Y N P
Tingling/ Numbness:	Y N P		Carpal Tunnel Syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P
<u>Mental/Emotional</u>				
Depression:	Y N P		Anger/Irritability:	Y N P
Suicidal:	Y N P		High-Strung/Tense:	Y N P
Anxiety:	Y N P		Fear/Panic:	Y N P
Eating Disorder:	Y N P		Psych Hospitalization:	Y N P

Exercise

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

Sleep

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

Nightmares:	Y N P	Wake Refreshed:	Y N P	Must nap during day:	Y N P
Sleep Walk:	Y N P	Grind Teeth:	Y N P	Snore	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? _____

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

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: _____

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

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

Social Life

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

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