PATIENT INFORMATION

Please Print

DATE_____

First Name_____Last_____MI_____

ADDRESS_____APT#_____

CITY/STATE/ZIP CODE_____

PHONE: (H)_____(W)_____(C)_____

D.O.B_____AGE_____SEX: M F STATUS: M S W SEP D

SOC. SEC. #_____-_____-_____OCCUPATION_____

EMPLOYED BY_____ADDRESS_____

CURRENT PROBLEM_____

IF AN ACCIDENT: DATE_____WHERE_____

EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US? Name_____Yellow Pages___

Please check the following conditions you have or have had:

Have	Had		Have	Had	
☐	☐	**Anemia/Blood Disease**	☐	☐	**History of Alcohol or Drug Abuse**
☐	☐	**Appendectomy**	☐	☐	**HIV**
☐	☐	**Arthritis/Rheumatism**	☐	☐	**Kidney Disease/Kidney Stones**
☐	☐	**Asthma/Emphysema**	☐	☐	**Knee of Joint Problems**
☐	☐	**Breast Surgery/Heart/Lung Surgery**	☐	☐	**Leukemia**
☐	☐	**Bronchitis/Chronic Cough**	☐	☐	**Loss of Consciousness/Dizziness**
☐	☐	**Cancer/Tumor**	☐	☐	**Neck/Back Problems**
☐	☐	**Cataract Surgery**	☐	☐	**Prostate Surgery**
☐	☐	**Color Blindness/Glaucoma**	☐	☐	**Rectal/Bowel Surgery**
☐	☐	**Deafness/Hearing Loss/Ringing in the ears**	☐	☐	**Removal of Spleen**
☐	☐	**Diabetes**	☐	☐	**Seizures/Epilepsy**
☐	☐	**Frequent of Severe Headaches**	☐	☐	**Sickle Cell Anemia**
☐	☐	**Gall Bladder Surgery**	☐	☐	**Sinus Problems/Hay Fever/Allergies**
☐	☐	**Gyn (female) Hysterectomy/Surgery**	☐	☐	**Stroke Paralysis**
☐	☐	**Gyn (female) Problems/Infections**	☐	☐	**TB/History of Positive Skin Test**
☐	☐	**Heart Disease/Heart Murmur**	☐	☐	**Thyroid Disease/Goiter**
☐	☐	**Hepatitis/Liver Disease/Jaundice**	☐	☐	**Tonsillitis/Adenoids/Ear Surgery**
☐	☐	**Hernia Repair**	☐	☐	**Ulcer/Digestive Problem/Bowel Disease**
☐	☐	**High Blood Pressure**	☐	☐	**Ulcers/Stomach Surgery**

Surgical Conditions _____

OTHER: _____

Known Allegries _____

CURRENT MEDICATIONS:	USED FOR WHAT CONDITION:

Family History

	Age: Current or at death	If deceased, give cause of death	Illnesses*	General Health
Mother				
Father				
Brother(s)				
Sister(s)				

*Please include cancer, diabetes, heart attacks, high blood pressure, strokes, TB and any other important illnesses

Personal Health Habits

Do you smoke?_____ How much?_____ How long?_____years Cigarettes__Cigars__Pipes__
Do you drink alcoholic beverages?_____ What kind?_____ How often?_____
Females: Are you pregnant?_____ Date of last menstrual cycle?_____
Primary Physician Name_____Phone Number_____

Authorization And Agreement For Medical Treatment

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

CONSENT TO TREATMENT: I understand that Oriental medical treatment is necessary for the patient and that independent physicians will perform treatment and procedures. I understand that Oriental medical treatment only is being provided and that no responsibility will be taken for long term patient care or care after normal operating hours. I hereby grant my authorization and consent to such treatment and procedures and certify that no guarantee or assurance has been made as to the results that may be obtained.

1. COMPLICATIONS: I understand that it is my responsibility to report to the clinic doctor any changes in my condition. A bruise, a bump, a hematoma, or red blister could develop. These generally should not be harmful but talk to your physician if you are concerned. Chinese Herbs have been used for thousands of years in China, but these herbal supplements have not been evaluated by the FDA. If you are concerned, seek the advice of your doctor.

2. AGREEMENT TO PAY FOR SERVICES: For and in consideration of the care and treatment provided, I promise to pay INTEGRATIVE MEDICINE CENTER all charges and services rendered to me. If I am using my insurance and it does not end up paying in full then I will be responsible for paying the remaining balance.

3. CANCELLING APPOINTMENTS OR NOT SHOWING UP: I understand that it is my responsibility to give 24 HOURS NOTICE to Integrative Medicine Center when I cannot make my scheduled appointment. FAILURE TO GIVE 24 HOURS NOTICE WILL RESULT IN A $25.00 CHARGE.

4. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: By my signature below, I acknowledge receipt of Integrative Medicine Center's Notice of Privacy Practices.

5. I HEREBY AUTHORIZE INTEGRATIVE MEDICINE CENTER to release any medical information in connection with these services for insurance purposes or to the patient's personal physician.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT AND HAS READ THIS AGREEMENT AND ACCEPTS ITS TERMS

Date:_____x_____

Signature of Patient