

NHIMA - NORTH HILLS INTEGRATIVE ASSOCIATES

PATIENT INFORMATION

Date _____
Name _____ Soc. Sec# _____ Date of Birth _____
Address _____ Apt _____
City, State _____ Zip Code _____ Telephone _____
Cell Phone _____ E-Mail Address _____ Marital Status _____

EMPLOYER INFORMATION

Employer _____ Patient Occupation _____
Employer address _____ City, State _____ Zip Code _____
Telephone _____ Ext _____ Fax _____

FINANCIALLY RESPONSIBLE PERSON (IF OTHER THAN PATIENT)

Name _____ Relationship _____
Address _____ City, State _____ Phone# _____

FINANCIAL RESPONSIBLE EMPLOYER INFORMATION

Employer _____ Employer Address _____
City, State _____ Zip Code _____ Phone# _____

EMERGENCY CONTACT

Name _____ Relationship _____
Home Phone _____ Bus Phone# _____ Cell# _____

INSURANCE INFORMATION

Subscriber Name & Date of Birth _____
Primary Ins. Carrier _____ Address _____
ID# _____ Plan# _____ Grp# _____
Effective Date _____ Soc Sec# _____ Secondary Ins Carrier _____
Plan# _____ Grp# _____

ASSIGNMENT & RELEASE OF INFORMATION STATEMENTS

I hereby authorize and direct NHIMA having treated me, to release to government agencies, insurance carriers or others who are financially liable for my hospitalization and/or medical care, all information needed to substantiate payment for such services rendered during my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. These agencies will be expected to maintain my confidentiality in accordance with standard practices.

I hereby assign, transfer and set over to the above named Medical group sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or other who are financially liable for my medical care to cover the cost of such care and treatment rendered to me or my dependents by assignment

Names of Patient /Authorized Representative

Patient (Representative) Signature

Date

NORTH HILLS INTEGRATIVE MEDICINE ASSOCIATES

APPOINTMENT POLICY

We allocate our time to provide the care and attention our patients need. It is imperative that you give us no less than 24 hour notice by phone of an appointment cancellation so that we can provide that time to another patient. We will charge your account a \$75 for less than a 24 hour notice or a missed appointment.

Patients that have missed two scheduled appointments without appropriate notice must contact the Office Manager prior to future appointments.

Patients with an account in arrears must contact the Office Manager prior to future appointments.

I have read this policy.

Signature

Patient/Parent/Guardian

Date

NORTH HILLS INTEGRATIVE MEDICINE ASSOCIATES

Consent for medical treatment

I hereby authorize North Hills Integrative Medicine Associates (NHIMA) to provide and administer diagnostic laboratory and X-Ray tests, medications and treatments as ordered by the physician.

Signature of Patient / Parent or Legal guardian(if a minor) Relationship Date

Authorization to release Medical Information

I authorize that my medical information can be left on my answering machine at home.

Yes No

I authorize that my medical information can be left on my voice mail at work.

Yes No

I want to be contacted by: Home _____ Work _____ Mail _____ Email _____

Signature _____ Date _____
Patient/ Legal Guardian/Parent Relationship

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for today's visit? _____

SYMPTOMS Check (✓) symptoms you currently have.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep/Dream Disturbed
- Loss of weight
- Nervousness
- Numbness
- Sweats
- Fatigue

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
- Weight Gain

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Difficulty Breathing
- Poor circulation
- Rapid heart beat
- Swelling of ankles/legs
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes/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 _____
How many children _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain/PMS
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____
- Date of last menstrual period _____
- Are menses regular _____
irregular _____
- # Days of menses _____
- Are you pregnant? _____
- Menopause/year _____
- How many pregnancies _____
- # of children _____

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Exzema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease/VD |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | |

MEDICATIONS List medications you are currently taking.

ALLERGIES To medications or substances

VITAMINS/NUTRITIONALS

Pharmacy Name _____

Phone _____

All information is strictly confidential

FAMILY HISTORY Fill in health information about your family.

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/SURGERY		
Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY		
Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates: _____

When was your last: (give year)
 PPD _____ EKG _____ Mammogram _____
 Tetanus _____ Colonoscopy _____ PAP _____
 Do you give consent to have an HIV Test to be done today? Yes No

Your Diet:

Breakfast	Snack	Lunch	Snack	Dinner

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

Water	_____ #of cups
Coffee	_____ #of cups
Tobacco	
Street Drugs	
Alcohol	

Exercise: Yes No
 How Often: _____ times per week

OCCUPATIONAL CONCERNS
 Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

 Signature of Patient, Parent, Guardian or Personal Representative

 Date

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

 Reviewed By

 Date