INTEGRATED HEALTH CARE

Patient Information

First:	M.I.:	Last:	Date:
Address:			
City:		State:	Zip+4:
DOB: / /	Age:	Sex: M F	Marital Status: S M D W
Indicate Primary Phone Number: ☐ Home #( )		☐ Work #( )	☐ Cell #/carrier( )
Email:		Spouse's Name:	
Employer:		Occupation:	

Name of your Health Insurance:	Insured Name:	DOB:
Relationship to Insured:		

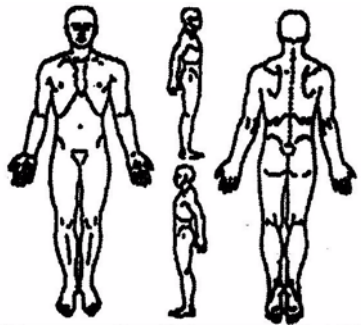
How were you referred to our office? (Please Circle)

Yelp Insurance Book/Website Friend/Previous Patient Office Website

Yoga Classes Palantir Attorney Other:_____

Is your complaint(s) today a result of an accident of any kind?		YES NO
Is this illness/injury under a Worker's Comp claim?		YES NO
Is this illness/injury under an automobile accident claim?		YES NO (if YES please give below)
Auto Insurance Co.	Claim #	Third Party? YES NO
Adjuster's Name	Phone #	Date of Accident

A: Please mark the exact location of pain.



B: Please circle your symptom(s) of concern

Fatigue	Headache	Blurred Vision
Tension	Migraine	Weak Muscles
Sleeplessness	Fever	Shoulder Pain
Nausea	Chest Pain	Elbow Pain
Swelling	Sore Throat	Wrist Pain
Stiffness	Diarrhea	Hand Pain
Dizziness	Earache	Knee Pain
Numbness	Tingling	Ankle Pain
Neck Pain	Back Pain	Foot Pain

C: List your Major Complain(s) today: _____

_____

D: Please describe, in your own words, what caused your condition(s) and/or when it started. _____

_____

480 S. California Avenue, Suite 103 • Palo Alto, CA 94306 • 650/321-7193 Fax: 650/327-2017

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History Form

Name: _____ D0B: _____ SS#:_____ Date: _____

PAST MEDICAL HISTORY

Hospitalizations	Year	Surgery/Illness	Hospital Address
1st			
2nd			
3rd			
4th			

ADDITIONAL MAJOR ILLNESS: (Please circle any that are applicable)
Liver, Thyroid, Kidney Diseases, Pancreatitis. Coronary Artery Disease, Rheumatic Fever, Bronchitis, Asthma, CO PD, Emphysema, Alcohol or Drug Addiction, Hemorrhoids, Inflammatory, Bowel Disease, Depression, Anxiety, Venereal Disease, Tuberculosis. Cancer, etc.

1. _____ 4._____ 7._____
2. _____ 5._____ 8._____
3. _____ 6._____ 9._____

TESTS: (Please indicate the date when the following tests were performed: month and year)

1. Mammogram _____ 2. Flu Shot _____ 3. Pelvic/Pap _____ 4. MRI_____
5. Sigmoidoscopy _____ 6. Rectal _____ 7. EKG _____ 8. NCV _____

SOCIAL HISTORY: Lives alone or with _____

☐ Smoke ____ pack/day for ____ years ☐ None
☐ Drugs: Marijuana Cociiine Opiates LSD Other ☐ None
☐ Alcoholic Beverage _____ glasses/week Beer _____ /week ☐ None

FAMILY HISTORY:

Please indicate illnesses listed above for each family member including age: at start of heart disease and type of cancer. If deceased, indicate age and cause of death.

Father
Mother
Sister 1
Sister 2
Brother 1
Brother 2
Other

MEDICATION: (Please list any medications you are currently taking)

I. _____ 4. _____ 7. _____
2 _____ 5. _____ 8. _____
3: _____ 6. _____ 9. _____

ALLERGIES: ☐ None

Medicines	Type of Reaction
I.	
2.	
3.	
4.	

Physician's Signature: _____

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