Integrated Health Solutions Inc.
Confidential Patient History

Patient's Name: _____ **Date:** _____

Please complete this form and questionnaire. If you need assistance, please ask. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Past Health History

1. Have you ever experienced your present problem before which you are consulting us: ☐ Yes ☐ No If yes, When: _____

   Was treatment provided? ☐ Yes ☐ No If yes, by whom: _____ Outcome: _____

2. Have you ever had a stroke or issues with blood clotting? ☐ Yes ☐ No If yes, when: _____
3. Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? ☐ Yes ☐ No If yes, explain: _____
4. Are you HIV positive, or have a blood borne pathogen disease? ☐ Yes ☐ No
5. Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries? ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Systems Review Questions

Do you or have you ever, had any problems with the following area?

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergies
14. _____ Psychological/Emotional

Females only:

15: _____ Gynecological/Menstrual/Breast

Males only:

16. _____ Prostate/Testicular/Penile

If yes, please explain: _____

Family History

List all major diseases such as cancer, diabetes, heart problems, etc. and the relationship of the individual to you:

Social History

Recreational Activities/Hobbies: _____

Yes	No		
☐	☐	Do you exercise? _____ times per week	
☐	☐	Do you smoke? _____ packs per day	
☐	☐	Do you use other forms of tobacco?	What/How much per day? _____
☐	☐	Do you consume alcohol?	How many drinks per week? _____
☐	☐	Do you eat a balanced dairy free anti-inflammatory diet?	If no, explain: _____
☐	☐	Do you get adequate sleep?	If no, explain: _____
☐	☐	Is work stressful to you?	If yes, explain: _____
☐	☐	Is family life stressful to you?	If yes, explain: _____

Current Symptoms

Chief complaint: _____

Secondary or related complaint(s) if any: _____

When did your symptoms begin: _____ Have you had this problem before? ☐ Yes ☐ No

Was the onset: ☐ Gradual ☐ Sudden Since the onset, has it gotten: ☐ Worse ☐ Better

Describe what caused the pain: _____

Have you detected possible relationship of your current complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other:_____

Have you tried any self-treatment or taken any medication (over the counter or prescription): ☐ Yes ☐ No

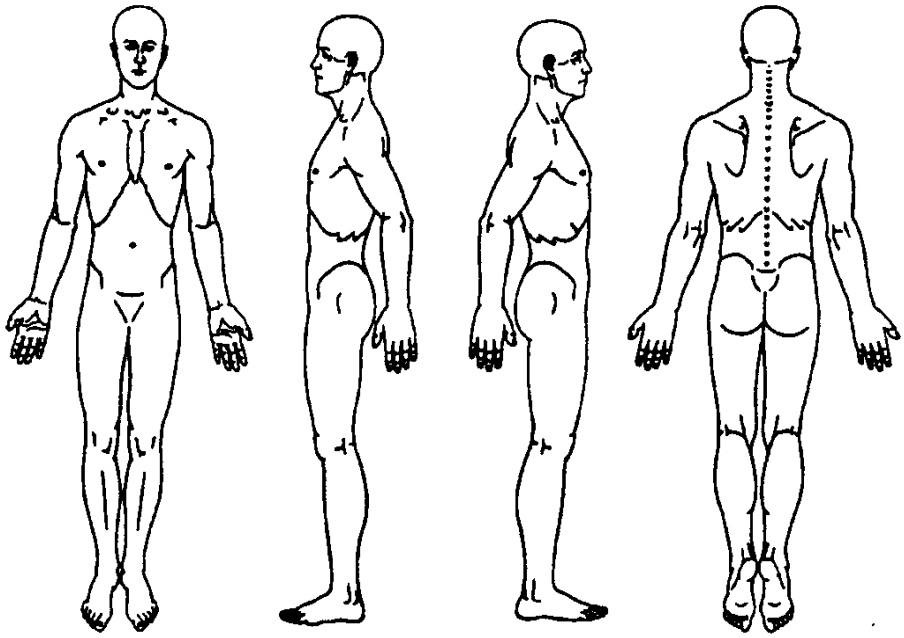
If yes, explain: _____ Results: _____

What medications are you currently taking: _____

Are you currently pregnant? ☐ Yes ☐ No Are you currently taking anti-coagulant or blood thinning medication? ☐ Yes ☐ No

Pain Chart
Please mark areas of pain using these codes:

B	**Burning**
D	**Dull/Ache**
N	**Numbness/Tingling**
T	**Throbbing**
S	**Stabbing/Sharp**



Front Left Right Back

Severity of Pain:
List region(s) of pain and circle the number which represents the intensity of your pain, with 0 being no pain, and 10 being unbearable pain:

1. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
2. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10
3. Complaint: _____ 0 1 2 3 4 5 6 7 8 9 10