Midtown Integrative Health & Wellness

515 Madison Avenue, 6th Floor

New York, NY 10022

Name:_____**Date of Birth**:_____
Last First mm/dd/yyyy

Address:_____
Street City, State Zip Code

Gender (please circle one): Male Female **Marital Status**: Single Married Divorced Widowed

Home Phone:_____ ☐ check if cellular phone **Work**:_____

Email Address:_____

We confirm all patient appointments via email.

☐ Check here if you would like to be added to our health newsletter mailing lists.

Primary Care Physician: _____ **Phone**:_____

How did you hear about us? Did someone refer you? _____

Occupation:_____

Employer's Name: _____ **Phone**:_____

Employer's Address:_____
Street City, State Zip Code

Emergency Contact:_____**Relationship**:_____ **Phone**:_____

Pharmacy & Address:_____ **Phone**:_____

Interest in health & wellness services:

Acupuncture	Yes	No
Bio-feedback Counseling	Yes	No
Cardiology	Yes	No
Chiropractic Care	Yes	No
Integrative Medicine	Yes	No
Internal Medicine	Yes	No
Massage Therapy	Yes	No
Non-surgical Orthopedics	Yes	No
Nutrition	Yes	No
Physical Therapy	Yes	No
Stress Management	Yes	No
Weight-Loss	Yes	No

I consent to treatment that is received in this office. I understand that my personal information is available to all medical providers at this location. I have received a copy of the office's notice of privacy practices and authorize the release of any medical or other information necessary to process a claim with my insurance. I request payment of insurance benefits either to myself or the party accepting assignment. I understand that I am responsible for any copay, deductible or expenses incurred that are not covered under my medical insurance.

Signature: _____ **Date**:_____

Patient Name:_____ **Date of Birth**:_____

What are your chief health concern(s)?_____

_____

How did your problem begin? _____

Have you had this problem before? Were any diagnostic imaging (x-rays, MRIs, etc) performed?

_____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If so, please list the type of treatment received and the contact information for the other doctor(s):

_____

_____

Please list any relevant medical history, including surgeries (type and year), injuries, hospitalizations, illnesses:

_____

_____

Has anyone in your family had a similar complaint?_____

Are you currently on any medications and supplements?

Name/Type	Dosage	Frequency	Date Started	Date Stopped

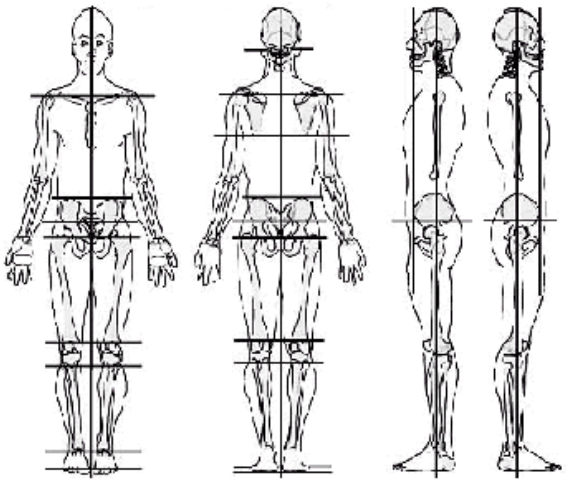
Please list any allergies:_____

Current height: _____ **Date of last measurement: _____**

Current weight: _____ **Date of last measurement: _____**

How much did you weigh in...high school? _____ 20s?_____30s?_____40s?_____50s?_____60s?_____

Circle the area(s) on the model if experiencing pain.



What makes the problem <u>better</u>? (select all that apply):

	Cold		Inactivity		Movement		Sitting		Walking
	Heat		Lying Down		Nothing		Standing		Other

What makes the problem <u>worse</u>? (select all that apply):

	Cold		Inactivity		Movement		Sitting		Walking
	Heat		Lying Down		Nothing		Standing		Other

How would you describe the pain? (select all that apply):

	Aches		Gripping/Constricting		Sharp/Stabbing		Tingling
	Burning		Itching		Soreness		Weakness
	Dull		Sharp/Dull		Throbbing/Gnawing		Other

How bad is your pain or problem? (please circle; 0 = no pain, 10 = unbearable) 0 1 2 3 4 5 6 7 8 9 10

How is your lifestyle being affected due to the pain?_____

What time is the pain most severe?_____ **Least severe**?_____

Preventative tests history:

	Month/Year of Last Test	**Test Results**
Blood Sugar		
Bone Density		
Cholesterol		
Colonoscopy		
EKG		
Mammogram		
Prostrate Screening		
Stress Tests		

Family medical history:

	Yes	No	
			If No, provide age of death:
Mother Living?			
Father Living?			
			Write relationship of relative(s) with the below conditions:
Allergies			
Arthritis			
Asthma			
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Prostate Cancer			
Seizures			
Skin Disorders			
Stroke			
Uterine/Ovarian Cancer			
Other Diseases/Conditions			

Personal medical history (check all that apply):

General

	Allergies		Convulsions		Fatigue		Loss of Sleep		Pain in Legs
	Bleed/Bruise Easily		Cravings		Headaches		Lyme Disease		Thyroid Disease
	Cancer (Specify)		Dental/Gum Issues		Hypo/Hyperglycemia		Numbness		Weight Gain
	Chills		Diabetes (Specify)		Iron Deficiency		Pain in Arms		Weight Loss
	Chronic Fatigue		Dizziness		Localized Weakness		Pain in Hands		

Additional information:_____

Cardiovascular

	Blood Clotting		High Blood Pressure		Poor Circulation		Shortness of Breadth
	Chest Pain/Pressure		Low Blood Pressure		Previous Heart Attack		Slow Heart Beat
	Cold Hands/Feet		Pain over Heart		Previous Heart Stroke		Sweat Easily
	Fainting		Paralytic Stroke		Rapid Heart Beat		Ankle Swelling
	Hardening of Arteries		Phlebitis		Reynaud's Disease		Varicose Veins

Additional information:_____

Gastrointestinal

	Bad Breath		Colon Trouble		Diverticulitis		Hepatitis/Liver Disease		Pain over Stomach
	Black Stools		Constipation		Excessive Hunger		Lyme Disease		Poor Appetite
	Bloating		Crohn's Disease		Gall Bladder Trouble		Hernia		Stomach Ulcers
	Blood in Stool		Diarrhea		Gas		Intestinal Worms		Strong Thirst
	Changes in Appetite		Difficult Digestion		Gastro-Esophageal Reflux		Irritable Bowel Syndrome		Vomiting
	Colitis		Distention of Abdomen		Hemorrhoids		Nausea		

Additional information:_____

Genito-Urinary

	Bed Wetting		Impotence		Menopausal Symptoms
	Blood in Urine		Inability to Control		Painful Menstrual Periods
	Cramps or Backache		Infertility Problems		Painful Urination
	Excess Flow		Kidney Infection		Pregnant
	Frequent Urination		Kidney Stones		Prostate Problems
	Herpes		Lumps in Breast		Pus in Urine

Additional information: _____

Head, Eyes, Ears, Nose and Throat

	Blurred Vision		Facial Pain		Peculiar Tastes/Smells
	Difficulty Swallowing		Grinding Teeth		Poor Vision
	Earaches		Jaw Clicks/Locks		Ringing in Ears
	Eye Strain or Pain		Night Blindness		Sinus Problems
	Face Flushing		Nose Bleeds		Spots in Front of Eyes

Additional information: _____

Musculoskeletal

	Arthritis		Fibromyalgia		Muscle Pain		Sciatica
	Artificial/Joint Problems		Foot/Ankle Pain		Neck Pain		Shoulder Pain
	Back Pain		Hand/Wrist Pain		Osteoporosis		Sprains/Strains
	Bursitis		Hip Pain		Rheumatoid Arthritis		Stiff Neck
	Carpal Tunnel		Knee Pain		Rotator Cuff		Tendonitis

Additional information:_____

Neuropsychological

	ADD/ADHD		Depression		Poor Concentration
	Alcoholism		Insomnia		Poor Memory
	Anorexia or Bulimia		Lack of Coordination		Psychiatric/Emotional Illness
	Anxiety/Excessive Stress		Numbness		Seizure Disorder
	Bad Temper/Irritable		Panic Attacks		Sexual/Libido Problems
	Concussion		Poor Balance		Vertigo

Additional information:_____

Respiratory

	Asthma		Difficulty Breathing		Phlegm
	Bronchitis		Emphysema		Pneumonia
	Coughing/Wheezing		Lung/Breathing Problems		Recurrent Sinus Infections
	Cystic Fibrosis		Pain with Deep Inhalation		Tight Sensation in Chest

Additional information:_____

Skin and Hair

	Acne		Itching		Skin Discoloration
	Change in Skin/Hair		Loss of Hair		Sores on Lips/Tongue
	Dandruff		Psoriasis/Eczema		Warts
	Fungal Infection		Rashes		Weak/Ridged Nails
	Hives		Recent Moles		

Additional information:_____

Social history (please circle all that apply):

Overall health	Excellent	Good	Fair	Poor
Physical fitness level	Excellent	Good	Fair	Poor
Under a lot of stress	Yes	No		
Difficulty dealing with stress	Yes	No		
Fatigued all the time	Yes	No		
Often sad or blue	Yes	No		
Practice meditation	Yes	No		

<u>Exercise habits</u>

Aerobic exercise	None	Routinely Exercise	# Hours/Week _____
	Jog	Walk	Run/Treadmill
	Stretching	Weight Lifting	Yoga
	Other_____		

Dietary habits

Try to eat healthy diet	Yes	No	
Special dietary habits	Avoid Red Meat	Gluten Free	Minimize Fat
	Avoid Dairy/Cheese	Minimize Carbs	Vegetarian
Emphasize fruits, grains, veggies	Yes	No	
Commonly eat fast food	Yes	No	
Commonly consume	Candy	Chocolate	Diet Soda
	Chips/Junk Food	Coffee	Regular Soda
Have you met with a dietitian before?	Yes	No	

If yes, for what reason(s)?

_____

What is one goal you'd like to accomplish by meeting with a registered dietitian?

_____

What, if any, worries and/or concerns do you have as you start your nutrition counseling?

_____

Tobacco use

Do you smoke	Yes	No	
Do you chew tobacco	Yes	No	
I smoke	Cigarettes	Cigars	Pipes
	#/Per Day_____	# Years_____	
I quit smoking (mo/yr)	_____		

Alcohol consumption

Do you drink alcohol of any kind	Yes	No	
I regularly drink	1-2 drinks/day	2+ drinks/day	4+ drinks/day
I typically drink	Beer	Wine	Other_____

Signature*:* _____ **Date:** _____