PORT CITY
INTEGRATIVE HEALTH

Your Name:_____ Date of Birth:_____ Age: _____
Address: _____City/State/Zip: _____
Phone (home): _____ (mobile): _____ (work):_____

Email:_____ Shall we add you to our e-newsletter? Y / N

Your Employer: _____ Employer Phone: _____
Employer Address: _____Your Occupation: _____

How did you hear of us?: _____ May we thank this person: Y / N
Ask us about our referral program. The best compliment is the referral of your friends and family.

Emergency Contact #1:
Name: _____
Phone Number: _____ Relationship: _____

Emergency Contact #2:
Name: _____
Phone Number: _____ Relationship: _____

Insurance Information
Insurance Company:_____
Name of Insurance Plan: _____
Is your insurance Private (Self) or Group Health Insurance:_____
Member ID#: _____ Group #: _____

Tell Us About You: Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you

When did you last receive healthcare? _____What was the reason? _____

_____

What are your **most important** health issues? Please list in order of importance.

1. _____ Treatments Prescribed: _____

2. _____ Treatments Prescribed _____

3. _____ Treatments Prescribed: _____

4. _____ Treatments Prescribed: _____

5. _____ Treatments Prescribed: _____

Surgeries, hospitalizations, imaging, injuries: Please list all CT, MRI, EEG, EKG and include *approximate dates:*

Personal Medical History: Please *circle* any that apply to you; *specify* ***now (N) or past (P)*** *with the respective "N" or "P". If you have never had the disease, leave it blank.*

Head, Ears, Eyes, Nose, Throat

Headaches N / P	Hearing Loss N / P	Blurry Vision N / P
"Floaters" in vision N / P	Corrective Lenses N / P	Dizziness N / P
Dry Eyes/Tearing N / P	Jaw/Teeth Problems N / P	Oral Sores/Pain N / P
"Ringing" in the Ears N / P	Ear Aches/Infections N / P	Chronic Sinus Problems N / P
Nose Bleeds N / P	Frequent Sore Throats N / P	Teeth Grinding N / P

Respiratory System

Shortness of Breath N / P	Chronic Cough N / P	Pneumonia N / P
Asthma N / P	Susceptibility to Colds/Flus N / P	Tuberculosis N / P
Hay Fever N / P		

Cardiovascular System

Diabetes N / P	High Blood Pressure N / P	Heart Disease N / P
High Cholesterol N / P	Stroke N / P	Palpitations N / P
Heart Murmur N / P	Chest Pains N / P	Swelling of Ankles N / P

Gastrointestinal System

Diarrhea N / P	Irritable Bowel Syndrome N / P	Chronic Constipation N / P
Crohn's/Ulcerative Colitis N / P	Nausea/ Vomiting N / P	Heartburn N / P
Gas and Bloating N / P	Gallbladder Disease N / P	Abdominal Pain N / P
Changes in Appetite N / P	Blood in Stool N / P	Hepatitis A,B or C N / P
Gluten Sensitive N / P	Food Intolerances N / P	

Genitourinary Tract

Kidney Disease N / P	Painful Urination N / P	Frequent UTIs N / P
Urinary Incontinence N / P	Kidney Stones N / P	Impaired Urination N / P
STI/STD N / P	HPV N / P	Blood in Urine N / P

Female Reproductive System/ Breasts

Cysts (breast/ovarian) N / P	Irregular Cycles N / P	Painful Periods N / P
Heavy Periods N / P	Bleeding Between Cycles N / P	Premenstrual Symptoms N / P
Vaginal Discharge N / P	Pelvic Pain N / P	Difficulty Conceiving N / P
Pregnancy N / P	PCOS N / P	Menopausal Symptoms N / P
Breast Cancer N / P	Uterine fibroids/polyps N / P	Endometrial Cancer N / P

Menstruating/ Birthing History

Age of First Menarche: _____ Age of Cycle Ceasing (if post-menopausal): _____
Length of Cycle: _____days Length of bleeding period: _____days
Number of Pregnancies: _____ Number of Live Births: _____
Method of Birth Control (if applicable): _____

Male Reproductive Health

Enlarged Prostate N / P	Prostate Cancer N / P	Sexual Difficulties N / P
Testicular Pain/ Swelling N / P	Infertility N / P	Hesitant Urination N / P

Musculoskeletal System

Arthritis N / P	Neck/Shoulder Pain N / P	Muscle Spasms/Cramps N / P
Low Back Pain N / P	Numbness/Tingling N / P	Joint Pain N / P _____

Endocrine System

Excessive Fatigue N / P	Hypothyroidism N / P	Hyperthyroidism N / P
Hypoglycemia N / P	Diabetes N / P	Night Sweats N / P
Cold Hands/Feet N / P	Hair Loss N / P	Excessive Thirst N / P

Mental Emotional Health

Mood Swings N / P	Depression N / P	Anxiety N / P
Excessive worry N / P	PTSD N / P	Irritability N / P

Other Medical History

SLE/Lupus N / P	Mental Illness N / P	Memory problems N / P
Epilepsy N / P	Eczema N / P	Psoriasis N / P
Anemia N / P	Eating Disorder N / P	HIV/AIDS N / P

Autoimmune Disorder Please List _____

Other Cancer N / P Please list: _____

Any additional medical history you feel it would be helpful for us to know:

Weight and Height:

Current Weight : _____ Past Maximum (If applicable): _____ When? _____

Height: _____

Childhood Illness (please circle):

Scarlet Fever Diphtheria Rheumatic Fever Mump Measles Chicken Pox

Immunizations (please circle)

Polio Tetanus Mumps/Measles/Rubella Pertussis Hib Diphtheria Hepatitis B

Others:

Current medications: Please list any prescription or over-the-counter treatments.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Herbs or supplements: Please list any herbal supplements, vitamins or homeopathic treatments.

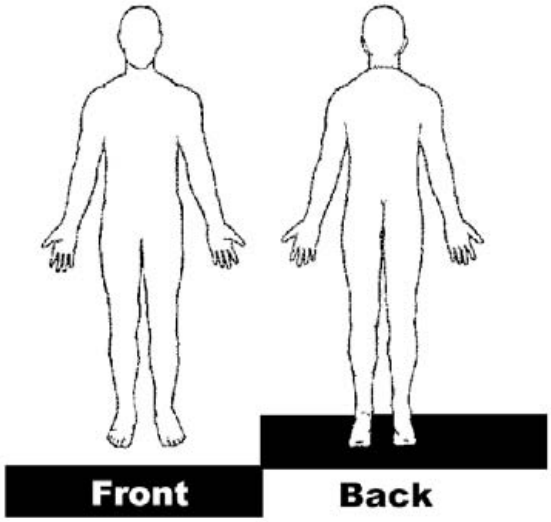
_____ _____

_____ _____

_____ _____

Do you have allergies/intolerances to medications or environmental? No /Yes
If yes, list medication/food/environment & describe reactions

Current Physical Discomfort
Please describe level of discomfort, chronic or acute. Mark pain/discomfort in the following areas:
0-1 No pain; 2-3 Mild pain; 4-5 Discomforting-moderate pain; 6-7 Distressing-severe pain 8-9 Intense-very severe pain; 10 Unbearable pain



Describe here:

What treatments have you tried for this physical discomfort in the past and present?

Family History: Please indicate any ***known*** health conditions; and *age at death* if applicable
Mother _____Father _____
Siblings _____Your Children _____
Maternal grandparents _____
Paternal grandparents _____
Additional info _____

Social History

With whom do you live? _____
Occupation(s): _____Length of time: _____
Do you have a religious or spiritual practice you would like to share with us? _____
What are your hobbies or interests?_____
Do you exercise regularly? **N / Y** If Yes, what type? _____
Cigarette Smoking History: Never, Past or Present? Amount per day? _____
TV or Computer Screen Time: Hours per day: _____

Context of Care Review

What **expectations/goals** do you have of **us** as your health care provider?

What is your **present level of commitment** toward addressing the underlying cause(s) of your symptoms? *Rate from 0 to 10 (10 being 100% committed).*

What behaviors or lifestyle habits do you regularly engage in which you believe ***support*** your health?

What behaviors or lifestyle habits do you currently engage in which you believe are ***self-limiting****?*

Who do you know that will sincerely and consistently *support you* with the beneficial lifestyle changes you will be making?

Other Medical Providers: Please list any other doctors, therapists, or other providers you are seeing

_____ _____

_____ _____

_____ _____

We thank you for taking the time to fill out this paperwork. We know how valuable your time is.