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ABOUT YOU:

Today's Date: _____

Name: _____

Male Female Date of Birth ___/___/___ Age ___ Height ___ Weight ___ SS# _____

Marital Status: Single Married Divorced Widowed Separated

Education: # of years completed: _____ Student _____

Home Address: _____
Street Address/P.O. Box City State Zip Code

Email address: _____ Who referred you? _____

Employed: Fulltime Part Time

Work Status: working without restrictions working with restrictions not working/off since _____

Home Phone #: _____ Work Phone #: _____ Job Description: _____

Employer Business Name: _____ Occupation: _____ Years Employed: _____

Employer's Address: _____
Street City State Zip Code

What is/are your presenting complaint(s)?

1. _____
2. _____
3. _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____
Phone #: _____ Relationship: _____

INSURANCE INFORMATION:

Self-pay

Please bill:

Auto Insurance

Worker's Compensation

Insurance Company ID #: _____ Health Insurance Other _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group #: _____ Subscriber's SS#: _____

Subscriber's Name: _____ Relationship: _____ Subscriber's Date of Birth: ___/___/___

Subscriber's Employer: _____

General Consent: I consent to evaluation and treatment. I understand that multiple treatment options exist, with varied risks and benefits, including drugs and surgery. I may choose not to receive treatment. If the risks and benefits of a proposed treatment/intervention are not clear, further information may be requested by me. I give full consent to receiving treatment, understanding that there are potential risks. Information within the patient chart is confidential. I understand that all requests for release of my records must be in writing and signed by me. I understand that I have a responsibility to communicate honestly to the Integrative Medicine health care team and notify them of any changes in my health status. If my condition is determined to be medically complex, or felt could benefit with physician management, with the primary goal of improving clinical outcomes and efficacy, I give full and unconditional consent that Paula Castro, MD manage, supervise or delegate care and bill me or my insurance for professional services.

Financial Consent: I understand I am financially responsible for all charges incurred by me, whether or not my insurance pays.

I assign my insurance benefits to Integrative Medicine Center/Paula Castro, MD. Any overpayment will be promptly refunded. I authorize Integrative Medicine Center/Paula Castro, MD to release protected health information to secure payment. Accounts over 90 days past due are subject to a monthly finance charge of 1.5%, 18% annually and collection costs.

Release of Records: I authorize _____ to release all health records necessary for my treatment and/or evaluation to Integrative Medicine Center/Paula Castro, MD.

Patient Signature _____ **Date** ___/___/___

Responsible Party Signature (If patient is a minor) _____ **Date** ___/___/___

Do you currently or have you had: Please mark all that apply
Current Past

Sleep Problems

Disabled
Nervous tension
Irritability

Mood Swings / changes

Do you currently or have you had: Please mark all that apply.
Current Past

Growing moles or lumps
Wear glasses or contacts
Glaucoma
Light bothers eyes
Other eye problems
Date of last eye exam: _____

Hearing difficulties
Ringing in ears
Sinus infection
Motion sickness
Dental Problems
Date of last dental exam: _____

Do you currently or have you had: Please mark all that apply.
Current Past

More frequent urination
Pain or blood with urination

Leaking urine
Urinating at night
Kidney or bladder infection
Kidney stones
Recurrent abdominal pain
Ulcers

Heartburn
Swallowing problems
Hernia
Hemorrhoids
Polyps
Loss of smell

Do you currently or have you had: Please mark all that apply.
Current Past

Arthritis or gout

Bursitis
Fractured bones
Seizures
Tremor
Passing out
Speech problems
Trouble concentrating
Diarrhea or constipation
Varicose veins

Do you currently or have you had: Please mark all that apply
Current Past

Asthma
Eczema
Hay Fever
Sinus Problems
Diabetes
High cholesterol or triglycerides

Thyroid trouble
Liver trouble
Anemia
Bleeding or bruising tendency

Do you currently or have you have: Please mark all that apply:
Current Past

High blood pressure
Racing, pounding heart
Ankle swelling
Lung or breathing problems
Pneumonia

Do you currently or have you had: Please mark all that apply:
Current Past

History of trauma
Infection
Unexplained weight loss
Unusual fatigue
Dizziness / Poor balance
Vomit blood
Bloody or black stools
Change in appetite
Fevers
Night Sweats
High blood pressure
Chest Pain
Shortness of breath
Chronic cough
Stroke
Heart disease or murmur
Loss of bowel or bladder control
Headaches
Muscle weakness or paralysis
Memory loss
Severe trauma
Direct head trauma
Lost consciousness
Poor coordination
Night pain
Difficulty Swallowing
Recent infection
History of osteoporosis
History of cancer
Difficulty breathing
Abdominal pain
Use of corticosteroids
Use of anticoagulants
Use of birth control pills
Numbness in groin (saddle anesthesia)
Loss of anal sphincter tone, fecal incontinence
(bowel accidents)
Pain fails to improve with rest
Pain greater than 4 weeks
Prolonged use of corticosteroids
Intravenous drug use

Patient Name _____
Date _____

ABOUT YOUR FAMILY HISTORY:

Please mark relative's current age or age at time of death, place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy – Asthma	Alcohol Abuse	Arthritis – Gout	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or back disorder	Stroke	Tuberculosis	Chronic Pain	Other	IF DECEASED, LIST CAUSE OF DEATH
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brother's & Sisters #1																				
#2																				
#3																				
#4																				
#5																				
Spouse																				
Children #1																				
#2																				
#3																				
#4																				
#5																				

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENT or WORK INJURIES

AREAS INVOLVED INDICATE TREATMENT

(Please be as specific as possible)

Year

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

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Name: _____

Date: _____

TESTS: Please list the MOST recent date:

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

HABITS: YES NO If yes, please describe:

Smoking Packs per day: 0 - 1/2 1/2 - 1 2 or more Duration _____

Alcohol Consumption # Drinks per day _____ Drinks per week _____

Coffee or Tea Consumption Cups per day _____

Other Drug Use (Street Drugs) _____

Exercise Daily Weekly Monthly Type _____

HOBBIES OR INTEREST: _____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, herbs

ALLERGIES: Please list all known allergies, especially to medicines. _____

Treatment you are receiving or have received:

Medical care Chiropractic care Other _____

Are you: Right handed Left handed Ambidextrous

Do you currently or in the past have: Please mark all that apply
Currently Past (When, #episodes)

Back pain or stiffness

Neck pain or stiffness

Shoulder pain

Hip pain

Foot pain or trouble

Swollen or painful joints

Cold hands or feet

Numbness or pain in the arms,
hands or fingers

Numbness or pain in the legs,
feet or toes

FEMALES ONLY

Do you have:

Menstrual problems Vaginal discharge

Abnormal bleeding Tubal infections

Breast lumps or pain Sex concerns

Problems getting pregnant

Age periods began: _____

Number of pregnancies: _____

Number of miscarriages or abortions: _____

Number of Cesarean Sections: _____

Type of birth control: _____

Date of last gynecological exam: _____

Date last period began: _____

Are you currently or possibly pregnant? _____

Date of Last Mammogram _____

MALES ONLY

Do you have:

Changes in urine stream Prostate trouble

Lumps in testicles Erectile Dysfunction

In general, how would you rate your health? Excellent Average Poor

What types of treatment are you interested in?: _____

DOCTOR'S NOTES: _____

Patient Name: _____ Date: _____