Hometown Integrated Medicine

321 S Columbus St Ste A Lancaster, Ohio 43130

Patient Name_____ Date: _____

Email: _____ SS #/SIN_____ DOB_____

☐ Male ☐Female Home phone_____ Cell Phone _____

Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address _____City _____

State_____ Zip_____

Employer Name:_____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____

Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____

Relationship to Patient _____

Address _____

Home Phone _____E-Mail _____

Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No

Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint:

_____

History of Present illness:

Location: _____ **Quality: _____**

(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____ **Duration: _____**

(How severe is the pain/problem on a scale of 1-10 with 10 being pain/ problem? the most severe?) (How long have you had this When did it start?)

Timing: _____ **Context: _____**

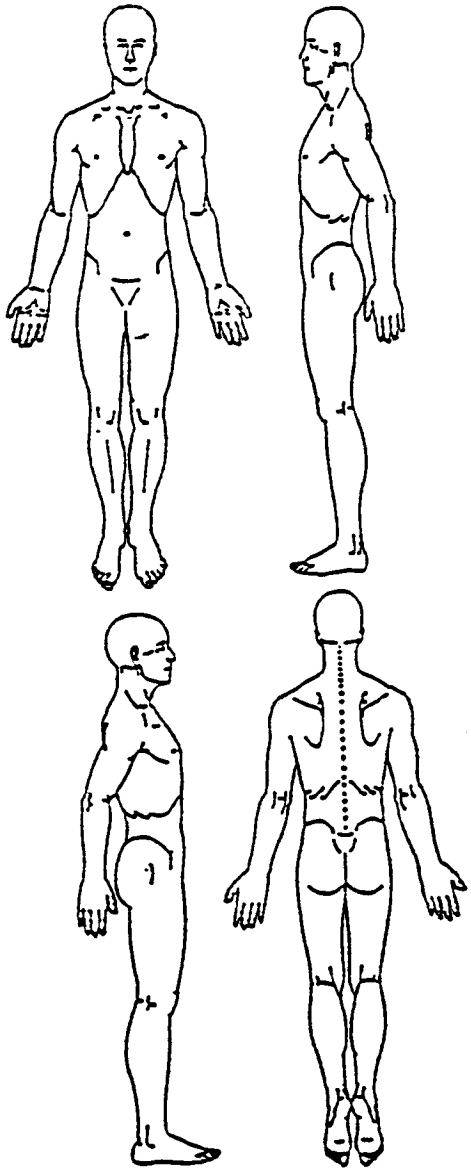
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ **Modifying Factors _____**

_____ _____

(What other associated problems have you been having?) (What makes it better/ worse?)

Are these complaints related to an Auto Accident? NO YES



Indicate any area of pain on picture

Past Medical History

(Have you ever had the following:
(circle "yes" or "no"/ leave blank if you are uncertain.)

Measles…… NO YES
Back Trouble…….NO YES
Mumps……. NO YES
High Blood Pressure…NO YES
Chicken Pox…… NO YES
Low Blood Pressure...NO YES
Whooping Cough… NO YES
Hemorrhoids…….NO YES
Scarlet Fever……. NO YES
Date of Last Chest X-Ray_____
Diphtheria…… NO YES
Asthma……..NO YES
Small pox…… NO YES
Eczema/ Skin Disorders NO YES
Polio……NO YES
Rheumatic Fever… NO YES
Infectious Mono…NO YES
Arthritis……. NO YES
Bronchitis……..NO YES
Mitral Valve Prolepse..NO YES
Stroke……NO YES
Crohns Disease NO YES
Gout……NO YES
Heart Attack… NO YES
Behavioral Issues NO YES

Anemia……..NO YES
Hepatitis……NO YES
Bladder Infection…….NO YES
Ulcer……NO YES
Epilepsy……NO YES
Kidney Disease……NO YES
Migraine Headaches. NO YES
Thyroid Disease……..NO YES
Tuberculosis……..NO YES
Bleeding Tendency…….NO YES
Diabetes……..NO YES
Ulcerative Colitis……NO YES
Cancer……NO YES
Pneumonia…….. NO YES
AIDS & HIV……NO YES
Glaucoma……NO YES
Rheumatoid Arthritis…. NO YES
Hernia……NO YES
Venereal Disease… NO YES
Transfusion……..NO YES
Chronic Fatigue Syndrome NO YES
Gallstones……NO YES
Heart Disease……..NO YES
Sinusitis……..NO YES
Frequent Ear/ Throat Infections……..NO YES
Food/ Seasonal Allergies NO YES

If yes to any of the previous questions, please explain: _____
_____

Previous Automobile Accidents:_____

Previous Injuries:_____

Previous Imaging Studies:_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____

_____ _____

_____ _____

Medication: (include nonprescription)

_____

_____

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily:

_____

Use of Drugs Never: _____ Type/Frequency:

_____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	Deceased, Cause Of Death
Father			
Mother			
Siblings			
Spouse:			
Children:			

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**	
Asthma	1 2 3 4 5	Muscle Aches/ cramping	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5

Sore throat 1 2 3 4 5
Chronic Cough 1 2 3 4 5
Chest Congestion 1 2 3 4 5
Frequent Sneezing 1 2 3 4 5
Itchy/Watery Eyes 1 2 3 4 5
Drainage 1 2 3 4 5
Earache or Ear Infection 1 2 3 4 5
Itching 1 2 3 4 5
Hoarseness 1 2 3 4 5
Shortness of Breath 1 2 3 4 5
Wheezing 1 2 3 4 5
Cry Eyes 1 2 3 4 5
Poor/ Double/ Blurred Vision 1 2 3 4 5
Floaters in Vision 1 2 3 4 5
Dental Issues 1 2 3 4 5

Neurological

Headaches 1 2 3 4 5
Migraines 1 2 3 4 5
Dizziness 1 2 3 4 5
Numbness 1 2 3 4 5
Tingling 1 2 3 4 5
Pins/needles in hands or feet 1 2 3 4 5
Forgetfulness 1 2 3 4 5
Poor Memory 1 2 3 4 5
Hair Loss 1 2 3 4 5
Night Sweats 1 2 3 4 5
Difficulty Swallowing 1 2 3 4 5

Other

Changes in Appetite 1 2 3 4 5
Indigestion/ heartburn 1 2 3 4 5
Acid Reflux 1 2 3 4 5
Abdominal Pain 1 2 3 4 5
Diarrhea or Constipation 1 2 3 4 5
Frequent/Painful Urination 1 2 3 4 5
Female Breast Issues 1 2 3 4 5
Female Menstrual Issues 1 2 3 4 5
Infertility Issues 1 2 3 4 5
Male Prostate Issues 1 2 3 4 5
Erectile Dysfunction 1 2 3 4 5

Joint Pain 1 2 3 4 5
Low Back Pain 1 2 3 4 5
Neck Pain 1 2 3 4 5
Wrist/Hand Pain 1 2 3 4 5
Elbow Pain 1 2 3 4 5
Shoulder Pain 1 2 3 4 5
Hip Pain 1 2 3 4 5
Knee Pain 1 2 3 4 5
Ankle/Foot Pain 1 2 3 4 5
Pain b/t shoulder blades 1 2 3 4 5
TMJ Issues 1 2 3 4 5
Stiffness in Joints 1 2 3 4 5
Balance Problems 1 2 3 4 5
Swollen Ankles 1 2 3 4 5
Pain that wakes me up 1 2 3 4 5

General

Fatigue 1 2 3 4 5
Malaise 1 2 3 4 5
Weakness, tiredness 1 2 3 4 5
Lightheadedness 1 2 3 4 5
Irritability 1 2 3 4 5
Constipation 1 2 3 4 5
Diarrhea 1 2 3 4 5
Feeling foggy 1 2 3 4 5
Cold Hands and Feet 1 2 3 4 5
Difficulty Falling/ staying asleep 1 2 3 4 5
Sensitive to Sun/ Fabrics/ Detergents 1 2 3 4 5
Cuts heal slowly 1 2 3 4 5
Acne 1 2 3 4 5
Burning on bottom of feet 1 2 3 4 5

Other Continued

Mood Disorders 1 2 3 4 5
Restless Legs 1 2 3 4 5
Considered Clumsy 1 2 3 4 5
Anxious/ Stressed 1 2 3 4 5
Feeling overwhelmed 1 2 3 4 5
Depressed 1 2 3 4 5
Jittery/Shaky 1 2 3 4 5
Bloating Issues 1 2 3 4 5

Alternative Treatments you have tried for your Conditions:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____

_____

Signature of Doctor Date

Hometown Integrated Medicine Does not accept insurance or Medicare and we do not file insurance paperwork on your behalf. However, we will provide a detailed receipt for services performed for you to submit to your insurance carriers. Some insurance carriers may partially cover medical services and laboratory tests performed by the physicians. Payment in full by check, cash or credit card is due at the time services are provided. I hereby understand and accept that I am fully financially responsible for the cost of care given at Hometown Integrated Medicine. I also agree to sign a separate ABN form before I receive any treatment acknowledging that Hometown Integrated Medicine is not billing or accepting my insurance.

_____ _____

Patient Signature Date