WELCOME

Five Stones Integrative Health
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1 PATIENT INFORMATION

Date______________________________

Name______________________________

Address______________________________

City State Zip______________________________

Age__________ Birthdate ______________

Occupation ______________________________

Primary physician ______________________________

Physician phone number______________________________

Whom may I thank for referring you?______________

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2 CONTACT INFORMATION

Home phone ______________________________

Work phone ______________________________

Email ______________________________

Best time and place to reach you ______________

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Another person whom we may contact if needed:

Name ______________________________

Relationship______________________________

Home phone ______________________________

Work phone______________________________

3 MEDICATIONS / HISTORY

List medications or food supplements you are taking.

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List serious illnesses, accidents or surgeries.

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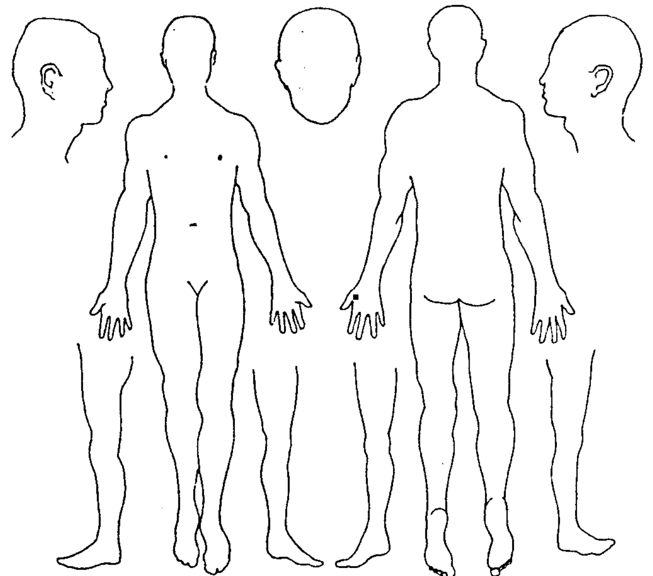
Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Cancer ☐ Heart disease ☐ Kidney disease

4

Please indicate painful or distressed areas if any.



Comments:

5 HEALTH HISTORY

Check symptoms you now have or have had in the last year.

- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry
- ☐ Excessive anger
- ☐ Excessive fear
- ☐ Fatigue/tiredness
- ☐ Headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

MUSCLE/JOINT/BONES
- ☐ Tremors ☐ Cramps
- ☐ Swollen joints

Pain, weakness, numbness in
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Other__________________

GASTROINTESTINAL
- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles

EENT/RESPIRATORY
- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ En larged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

GENITO/URINARY
- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

FOR MEN ONLY
- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

FOR WOMEN ONLY
- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant?_____

Check conditions you have or have had in the past.

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

How long has it been since you have had a complete medical exam?

____

6 LIFESTYLE

Check which substances you use and describe how much you use.

- ☐ Caffeine ______________________
- ☐ Drugs ______________________
- ☐ Alcohol ______________________
- ☐ Tobacco ______________________
- ☐ Sugar ______________________

Check if your work or lifestyle exposes you to these.

- ☐ Stress
- ☐ Insufficient sleep
- ☐ Very long working hours
- ☐ Long commuting times
- ☐ Heavy lifting or hazardous substances
- ☐ Other______________________

7 SIGNATURE

The information on this form is correct to the best of my knowledge. I understand that my protected health information will be used and disclosed consistent with the policies in this office's Notice of Privacy Practices.

Signature______________________________ Date ________________