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NEW PATIENT HEALTH HISTORY

Welcome To Integr8 Health. Thank You For Choosing Us For Your Health Care.

Name: ______________________________ Date of Birth: ______________ Age: ________

PLEASE STATE YOUR CURRENT HEALTH CONCERN(S):

____

____

PAIN PATTERNS MAP →→→

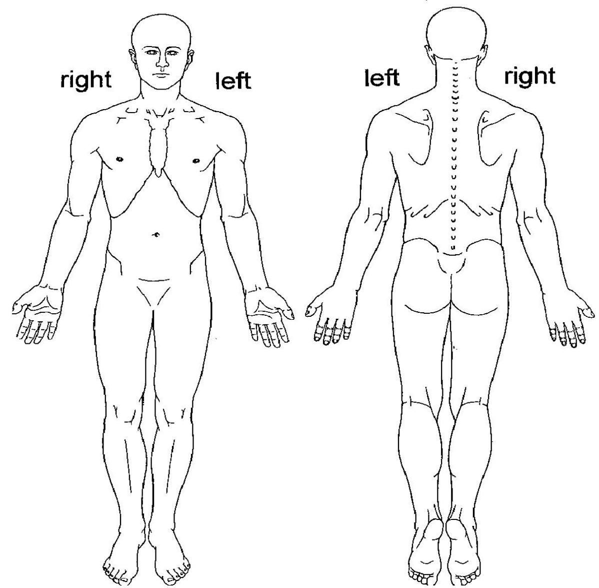
On the figures provided to the right, please "illustrate" your areas of pain and/or numbness using the following key:

Moderate Pain = O O O O O

Severe Pain = X X X X X

Numbness = N N N N N

or tingling.



FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

What are the symptoms?

____

What makes it better, and what makes it worse?

____

____

____

Does it interfere with your ability to function or sleep? Please describe.

____

____

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When and how did this condition start?

____

____

What types of examinations have you had (doctors seen, tests performed, etc.)?

____

____

What treatments have you tried and how well have they worked?

____

____

PLEASE LIST YOUR CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage):

____

____

____

____

PLEASE LIST ANY ALLERGIES (medications, food or environmental & your reactions):

____

____

DO YOU CURRENTLY HAVE A PRIMARY CARE PROVIDER? YES NO

Name & Town / Practice____

What other medical providers are involved in your care?

____

____

CANNABIS HISTORY:

Are you currently using cannabis? YES NO (If no, please skip to next section).

How? Please circle: pipe, joint, vaporizer, tincture, edible, juicing, topical, concentrates, other:_________

How much cannabis do you use? (eg. 2 puffs twice daily,1⁄4 ounce per week, 40mg daily, etc.)

____

Which strains work well, which don't?

____

How does cannabis help you?

____

____

Have you had any negative effects from cannabis? YES NO If yes, please describe:____________

____

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MEDICAL HISTORY:

Please list any other major health problems, hospitalizations, and surgeries that you have had and when:

____

____

____

Please list any traumas you have experienced (accidents, falls, head injuries, abuse as a child, loss of loved ones, fires, abusive relationships, sexual assault, military combat, etc.):

____

____

____

Have you been diagnosed with any of the following illnesses? (please circle)

Fibromyalgia, Chronic Fatigue Syndrome, POTS, Rheumatoid arthritis, Lupus, Multiple Sclerosis, ALS, Bell's Palsy, Costochondritis, Transverse Myelitis, Idiopathic Neuropathy, Dementia.

Have you ever been bitten by a black legged (deer) tick? **YES NO**

If yes, did you get a circular rash in the area of the bite? **YES NO**

Have you ever experienced a strong flu like illness in the summer or fall from which you never fully recovered? **YES NO**

Do you have any of the following symptoms? (please circle)

Joint pain or swelling; Severe fatigue that is worse after activity; Numbness; Tingling; Radiating pain; Muscle or tendon aches; Pain in your ribs, chest, or between the shoulder blades; Swollen glands; Unexplained fevers, sweats, or chills; Unexplained lapses in memory, attention, concentration, or the ability to process numbers; Unprovoked mood swings; Feel like you've aged prematurely.

Do the above problems seem to come and go without a clear cause? **YES NO**

Have you noticed a pattern in the occurrence of these symptoms (e.g. monthly)? **YES NO**

Do the symptoms move around from one area of the body to another or switch sides? **YES NO**

Other Symptoms (Please circle any that you've experienced in the last 2 weeks):

GENERAL: Persistent Fatigue; Weakness; Fever/chills; Dizzy; Fainting; Weight loss/gain

HEAD: Headaches; Eye pain; Trouble seeing; Trouble hearing; Ringing in ears; Ear pain; Stuffed nose; Tooth pain; Sore throat; Swollen glands.

BREATHING: Cough; Excess phlegm; Bloody phlegm; Shortness of breath; Wheezing.

HEART & CIRCULATION: Chest pains; Swollen ankles; Trouble breathing when laying down; Trouble walking up stairs; Legs cramp after walking; Heart races or skips beats.

DIGESTIVE: Heartburn or reflux; Belly pain; Poor appetite; Nausea; Vomiting; Constipation; Diarrhea; Blood in vomit or stools; Black or tarry stools; Excess belching or passing gas; Rectal pain.

URINARY: Pain or burning with urination; Frequent urination; Blood in urine; Decreased urine stream; Leaking urine.

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MUSCULOSKELETAL: Back pain; Painful muscles; Painful joints; Swollen joints; Morning stiffness; Muscle cramps.

NEUROLOGICAL: Radiating pain; Tingling; Numbness; Weakness; Blackouts; Tremors; Seizures; Trouble with balance or coordination; Memory changes.

MENTAL HEALTH: Persistent sadness; Worry; Anxiety; Guilt; Fear; Paranoia; Over-energized; Trouble paying attention; Panic attacks; Irritability; Flashbacks; Under-eating; Overeating; Thinking about harming myself / another.

OTHER: Can't tolerate heat / cold; Excessive sweating; Nipple leaking; Change in appetite / thirst; Rash; Skin changes; Changed libido; Trouble or pain with sex.

FOR WOMEN: Irregular bleeding; Problems with periods; Lumps in breasts; Vaginal dryness; Hot flashes.

FOR MEN: Erection problems; Lumps or pain in testicles.

FAMILY MEDICAL HISTORY:

Mother____

Father____

Siblings____

Grandparents______________________________________Other_____________________________

LIFESTYLE AND SOCIAL LIFE:

How many cups or glasses do you drink per day? water:_____ caffeinated beverages:_______

What else do you drink and how much?____

How many alcoholic beverages do you drink per week? _______________________________

Tobacco (type, how much & how long)? ____

How much exercise do you get per week & what kind? _______________________________

____

____

How many hours of sleep do you get each night? _______ Do you feel rested in the morning?_________

Have you had any recent major life changes?

____

____

What do you do for fun and relaxation?

____

____

With Whom do you live?____

____ Do you feel safe at home? YES NO

Are you? Employed____ Unemployed____ Disabled____ Other___________________________

What do you do for work?

____

Name:____ Date of Birth___________________

WHAT ARE YOUR HEALTH AND HEALING GOALS? WHAT ARE YOUR GOALS FOR THIS VISIT?

____

____

____

THE FOLLOWING SECTION IS USED FOR RESEARCH – WE APPRECIATE YOUR RESPONSES!

PLEASE CHOOSE 1 OR 2 SYMPTOMS (PHYSICAL OR MENTAL) THAT BOTHER YOU THE MOST.
Write them on the lines. Now consider how bad each symptom has been, on average over the last week, and score it by circling your chosen number.

Symptom 1.____________________________ 0 1 2 3 4 5 6

Symptom 2.____________________________ 0 1 2 3 4 5 6

(0 = as good as it could be) (6 = as bad as it could be)

Please choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

Activity:________________________________ 0 1 2 3 4 5 6

(0 = as good as it could be) (6 = as bad as it could be)

How would you rate your general feeling of wellbeing during the last week?

0 1 2 3 4 5 6

(0 = as good as it could be) (6 = as bad as it could be)