NEW PATIENT HEALTH HISTORY

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

Name: _____ Date of Birth: _____ Age: _____ Today's date:_____

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

_____

_____

PLEASE LIST YOUR CURRENT HEALTH CONCERN(S):

_____

_____

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? Please describe.

_____

_____

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?

_____

_____

PAIN PATTERNS MAP →→→

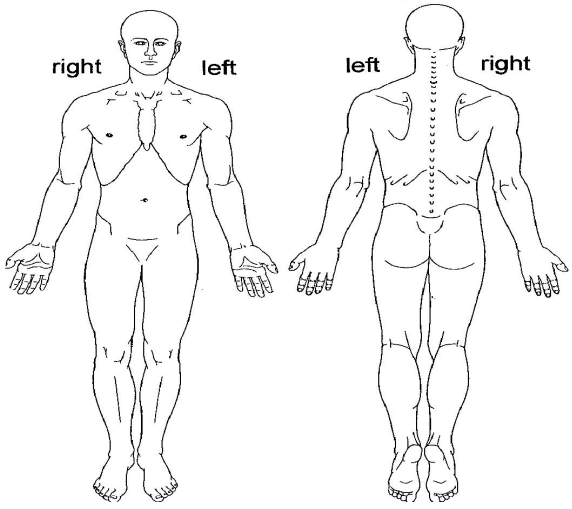
On the figures provided to the right, please "illustrate" your areas of pain and/or numbness using the following key:

Moderate Pain = O O O O O

Severe Pain = X X X X X

Numbness = N N N N N

or tingling.



CANNABIS HISTORY

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

How? Please circle: pipe, joint, vaporizer, pen, tincture, edible, tea, topical, concentrates, other:_____

How much? (e.g. 20mg CBD 3x/day, or 2 puffs 2x/day, or 1⁄4 oz/week) _____

What works well, what doesn't? _____

How does cannabis help you? _____

_____

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

_____

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? _____

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 (abuse as a child, abusive relationships, sexual assault, military combat, fires, accidents, falls, head injuries, loss of loved ones, etc.):

_____

_____

FAMILY MEDICAL HISTORY

Please list any significant health problems in your family members:

Mother_____ Father_____

Siblings_____

Grandparents_____ Other_____

LIFESTYLE AND SOCIAL LIFE:

With Whom do you live?_____

Do you feel safe at home? YES NO

Are you? Employed____ Unemployed____ Disabled____ Student____ Other_____

What do you do for work? _____

What do you do for fun and relaxation? _____

_____

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?_____

How many servings do you drink per day? water_____ caffeinated beverages_____ alcohol (per week)_____

What else do you drink and how much?_____

How would you describe your diet?_____

What did you eat yesterday?_____

_____

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

Have you had any recent major life changes?_____

OTHER SYMPTOMS (Please circle any that you've experienced <u>in the last 2 weeks</u>):

GENERAL: Persistent Fatigue; Weakness; Fever/chills; Night sweats; Dizzy; Fainting; Weight loss/gain; Swollen glands; Feel like you've aged prematurely.

HEAD: Headaches; Eye pain; Trouble seeing; Trouble hearing; Stuffed nose; Tooth pain; Sore throat.

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

HEART & CIRCULATION: Chest pains; Swollen ankles; Trouble breathing when laying down; Trouble walking upstairs; 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; Leaking; Blood in urine; Decreased stream.

MUSCULOSKELETAL: Back pain; Painful muscles or tendons; Painful joints; Swollen joints; Morning stiffness; Muscle cramps; rib pain. Pains that come and go or move around w/out a clear reason.

NEUROLOGICAL: Radiating pain; Tingling; Numbness; Weakness; Blackouts; Tremors; Seizures; Trouble with balance, coordination, memory, attention, concentration, or the ability to process numbers.

MENTAL HEALTH: Persistent sadness; Worry; Anxiety; Guilt; Fear; Paranoia; Over-energized; Unprovoked mood swings; 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.

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