INTRINSIC INTEGRATIVE HEALTH

Confidential Patient Information

Intrinsic Integrative Health
2500 Youngfield St, Ste 6
Lakewood, CO 80215

P: (720) 924-6535
F: (720) 863-2003
www.youriihealth.com

Patient's Full Name _____ Date:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____ ☐ Married ☐ Single ☐ Other_____

Spouse's Name:_____ Number of Children/Ages_____

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed ☐ Other:_____

Occupation:_____ Employer:_____

Employer Address:_____ City:_____ State:____ Zip:_____ Phone #:_____-_____-_____

How did you find us?

☐ Existing Patient
Who?_____

☐ Physician
Who?_____

☐ Friend
Who?_____

☐ Other_____

☐ iiHealth Website

☐ Google

☐ Other Website:_____

Primary Care Physician (PCP):

PCP Group Name: _____ Physician's Name: _____

Address:_____ Phone #:_____-_____-_____

City:_____ State:_____ Zip:_____

Emergency Contact:

Contact Name: _____ Relationship:_____ Phone #:_____-_____-_____

Is Today's Visit Due To A Work-Related Injury? ☐ Yes ☐ No
Is Today's Visit Due To An Auto Accident? ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Authorization and Assignment

In consideration of my undertaking of care by iiHealth provider, I agree to the following:

1. Authorization to release **any information** deemed appropriate by iiHealth concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceed, if applicable.
3. I hereby assign and transfer to Intrinsic Integrative Health (iiHealth) the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to iiHealth for the charges made for service. I authorize iiHealth to prosecute said action in my name, if applicable. I further authorize iiHealth to compromise, settle, or otherwise resolve said claim as seen fit. I understand that whatever amounts iiHealth does not collect from insurance companies, whether it be all or part of what was due, **I personally owe to Intrinsic Integrative Health**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (iiHealth) are **paid in full**.

Patient Signature:_____ **Date:**_____/_____/_____

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Dear Patient: Please complete this form completely. If you need assistance, please ask. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

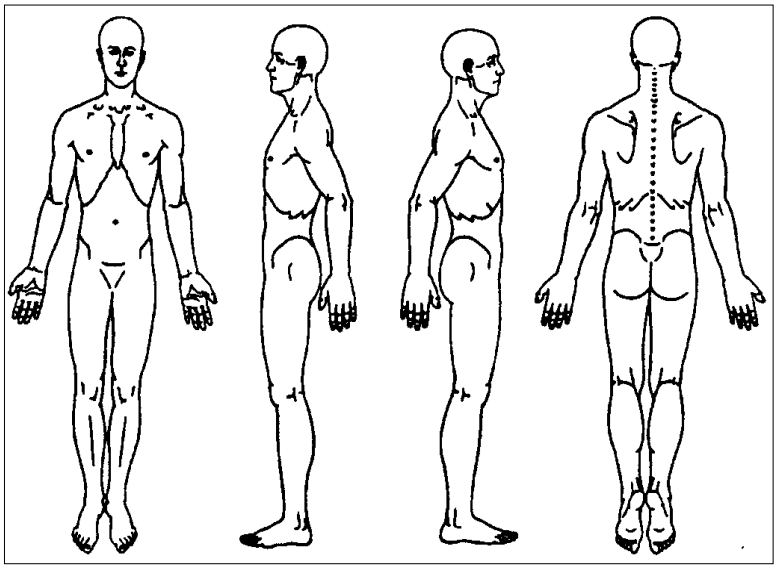
Present complaint(s):_____

When did your symptoms begin? (Specific date if possible)_____

How did your symptoms begin? (i.e. Lifting, ect.)_____

In the past have you had anything like this? ☐ Yes ☐ No Please explain_____

Please Mark the Areas of Pain or Dysfunction Below then Describe Your Pain



DESCRIBE YOUR PAIN

#1 Complaint_____ _____

(Rate your level of Pain)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #2 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

DESCRIBE YOUR PAIN

#2 Complaint (if applicable) _____

(Rate your level of Pain)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

DESCRIBE YOUR PAIN

#3 Complaint (if applicable) _____

(Rate your level of Pain)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #3 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_____

How often are your complaints present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

***Check each following box that applies to your pain(s), and place the Complaint # next to its corresponding box:**

Is your Pain:	**Was the Onset:**	**Pain is aggravated by:**	**Pain is improved by:**
☐ Increasing	☐ Gradual	☐ Walking ☐ Lifting	☐ Medication ☐ Chiropractic Adjustment
☐ Decreasing	☐ Sudden	☐ Sitting ☐ Bending	☐ Rest
☐ Not Changing		☐ Riding in a car ☐ Stretching	☐ Exercise
☐ Varies		☐ Standing ☐ Twisting	☐ Therapy
		☐ Other_____	☐ Other_____

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem? _____

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Chiropractic Dr.'s Name: _____ City: _____ State: _____

Primary Care Physician(PCP): _____

☐ Yes ☐ No For the purpose of your best interest, is it okay to inform your PCP of your co-therapy with us?

☐ Yes ☐ No Is pain affecting your ability to work or be active? If **Yes** explain: _____

_____

☐ Yes ☐ No Any change in bowel or bladder (bathroom) function? If **Yes** explain: _____

☐ Yes ☐ No Any fever or chills? If **Yes** explain: _____

☐ Yes ☐ No Any dizziness associated with symptoms? If **Yes** explain: _____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If **Yes** explain: _____

_____

☐ Yes ☐ No Are your complaints affecting your sleep? If **Yes** explain: _____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. X-rays, MRI, CT) If **Yes** explain:_____

☐ Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If Yes explain: _____

☐ Yes ☐ No Have you ever been in the hospital for any reason? If **Yes** explain:_____

_____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? If **Yes** explain: _____

_____

☐ Yes ☐ No Have you had any prior treatment, including any physical therapy?

If **Yes**, who? _____

What treatment?_____

☐ Yes ☐ No Have you ever been in an accident? If Yes explain:

_____

☐ Yes ☐ No Do you smoke? If Yes how much? _____

If you have quit smoking, when did you quit?_____

☐ Yes ☐ No Do you consume alcohol? If yes, approximate how many drinks/week? _____

☐ Yes ☐ No Do you exercise? If **Yes** what is your routine? _____

What type of care are you interested in?

☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

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Please circle all conditions that apply:

Nose/Mouth/Throat:
Nose bleeds
Loss of smell
Dry sinuses
Sinusitis
Sore tongue
Bleeding gums
Mouth sores
Hoarseness
Acid/bitter taste
Trouble swallowing

Cardiovascular:
Chest pain
Heart palpitation
Heart murmurs
High blood pressure
Cramping-legs
Varicose veins
Swelling-arms/legs

Immunology/Allergy:
Rhinitis
Seasonal allergies
Latex allergy
Food allergy/sensitivity
Medication allergy

Gastrointestinal (GU):
Trouble urinating
Pain with urination
Blood in urine
Cloudy urine
Urgency
Frequent urination at night
Incontinence/dribbles
Kidney stones
Rash in genitals
Sexual problems
Sexually transmitted diseases

GU (*continued*)
Women only:
Vaginal discharge
Abnormal period
Pregnant
Abortion/miscarriage
Still birth
Men only:
Painful ejaculations
Penile discharge
Poor urinary stream

Respiratory:
Chronic dry cough
Cough with mucus
Coughing up blood
Pneumonia
Night sweats
Wheezing
Chest pain w/breathing
Shortness of breath
Asthma

Eyes:
Pain
Redness
Loss of vision
Double vision
Blurred vision
Change of vision
Flashing Spots
Dryness
Glasses/contacts

Ears:
Ringing in ears
Loss of hearing
Hearing Aids
Positional vertigo

Musculoskeletal:
Muscle cramps
Joint pain
Weak muscles
Joint swelling
Neck pain
Back pain
Joint replacement
Fractures

Hermatology/Lymphatics:
Anemia
Easily bleed
Easily clot

Gastrointestinal (GI):
Nausea
Vomiting food
Heartburn
Regurgitation/wet burp
Belching
Diarrhea
Constipation
Excessive gas
Blood in stool
Hemorrhoids

Neurologic:
Diabetes
Neuropathy
Chronic headaches/migraines
Dizziness
Numbness (hands/feet)
Tingling (hands/feet)
Unconsciousness
Memory loss
Balance problems
Epilepsy

Endocrine:
Sensitive to cold
Sensitive to heat
Increased thirst
Decreased sex drive
Thyroid
Parathyroid

Psychiatric:
Depression
Anxiety
Hearing voices
Thoughts of suicide
Obsessive/compulsive habits
Problems concentrating
History of abuse

Integumentary/Breasts:
Change in skin
Yellow skin
Change in hair
Easy bruising
Skin redness
Hives
Sensitive to sun
Skin tightness
Nodules/bumps
Hair loss
Color change of hands/ feet with cold
Persistent sores
Change in moles
Change in nails
Breast lumps
Breast pain
Nipple discharge

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What **non-prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other_____

How often?
☐Daily ☐Weekly ☐Other: _____

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Diet Pills
☐ Pain Killers ☐ IUD ☐ Nerve Pills
☐ Muscle Relaxers ☐ Cholesterol Meds ☐ HRT
☐ Blood Pressure Meds ☐ Insulin ☐ Sleeping Aid
☐ Tranquilizers

☐ Other_____ ☐ None

Specific names if possible:
_____

YOUR FAMILY HISTORY'S HEALTH STATUS: List any diseases, disorders, or major illnesses your immediate family has/had. If deceased, from what? (This information may help determine your familiar susceptibilities to illness, disorders, etc. and help our doctors better diagnose and treat your condition.)

Mother:_____ Father:_____

Brother(s):_____ Sister(s):_____

Other:_____ Other:_____

Do you have any other health concerns or diseases diagnosed in addition to those already reported in these forms?
_____

Do you have specific dietary guidelines you follow? ☐ Gluten Free ☐ Dairy Free ☐ Vegetarian/Vegan

☐ Other:_____

☐ Yes ☐ No Do you consume artificial sweeteners? If so, please specify: ☐ Sweet N'Low/Sugar Twin/Saccharine
☐ Splenda/Sucralose ☐ Equal/NutraSweet/Aspartame ☐ Sweet One/Swiss Sweet/cesulfame-K

☐ Other _____

☐ Yes ☐ No Do you consume diet beverages such as soda, sports drinks, tea, or others?

If so, please specify type(s): _____

Yes ☐ No Do you belong to a local gym, sport team/league, etc.?

If so, please specify type(s): _____

☐ Yes ☐ No Would you like more information on Nutrition and Supplement recommendations, or review of your health file and/or past labs with a Functional Medicine Internist?

Thank you for taking the time to complete this packet so that we may more accurately help you with your health and wellness journey!