SCOTT FAMILY HEALTH
Chiropractic | Massage | Acupuncture | Physical Therapy

INTEGRATIVE HEALTH

Patient Health History Form

Today's Date: ____/____/_____

Patient Information:

Patient First Name:	**Middle Initial:**	**Last Name:**

Patient Address:		
Patient City:	**Patient State:**	**Patient Zip:**
Home Phone:	**Mobile Phone:**	**E-mail:**
Date Of Birth:	**Gender:**	**Marital Status:**
How did you hear about us?		

Primary Care Physician:	**Physician Phone Number:**

*****INTEGRATIVE HEALTH MEMBERS MUST DECLARE DR. JAMES HOWTON AS PCP*****

SUBSCRIBER Name:	**SUBSCRIBER Date of Birth:**
Insurance:	**Member ID:**
Group Number:	

Insurance Information (If you are not going through insurance please skip):

Pregnant ❑ Yes ❑ No **How many weeks** _____

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Vietnamese ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean
❑ Asian ❑ Native Hawaiian or other Pacific Island ❑Samoan ❑ Guamanian or Chamorro
❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese
❑ French ❑ German ❑ Tagalog ❑ Vietnamese ❑ Italian
❑ Korean ❑ Russian ❑ Polish ❑ Arabic ❑ Portuguese ❑ Japanese
❑ French Creole ❑ Greek ❑ Hindi ❑ Persian
❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Have you traveled out of the U.S. recently ❑ Yes ❑ No **If yes, where** _____

Reason For Consultation (IF YOU ARE NOT A MEMBER PLEASE SKIP TO SYMPTOMS SECTION)

Any health concerns?
What would you most like to achieve with your membership in our health program?
List any questions that you would like our team to address?

Symptoms- Describe Your Problem (Fill in as necessary)

Symptom 1_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other_____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day

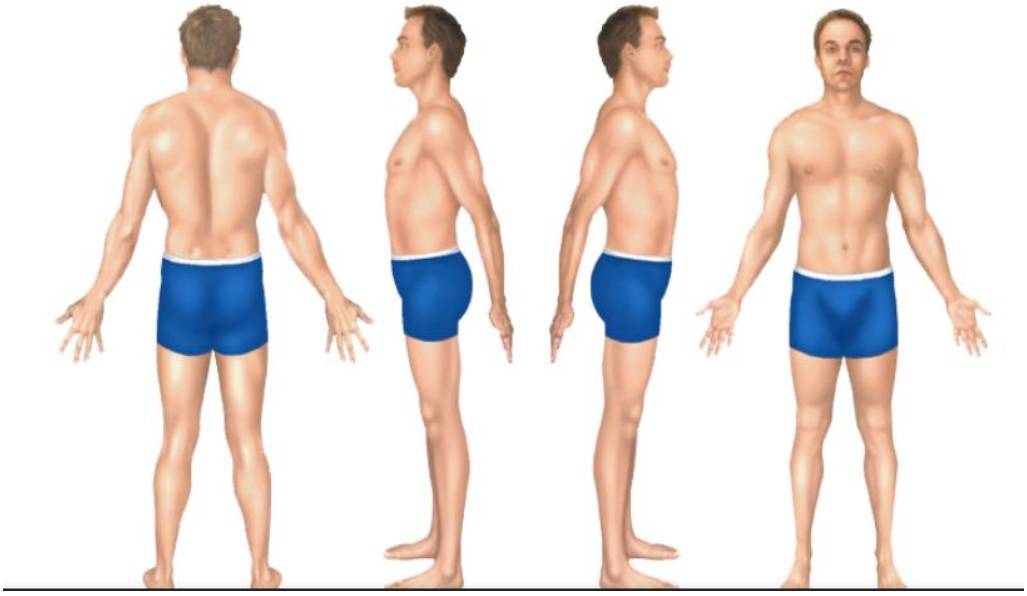
Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other_____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
    - Bending neck forward/backward Tilting head to left/right turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
    - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other_____
- Does the symptom radiate to another part of your body? (circle one) Yes No
    - If yes, where does the symptom radiate?_____
- Is the symptom worse at certain times of the day or night? (circle one):
    - Morning Afternoon Evening Night Unaffected by time of day

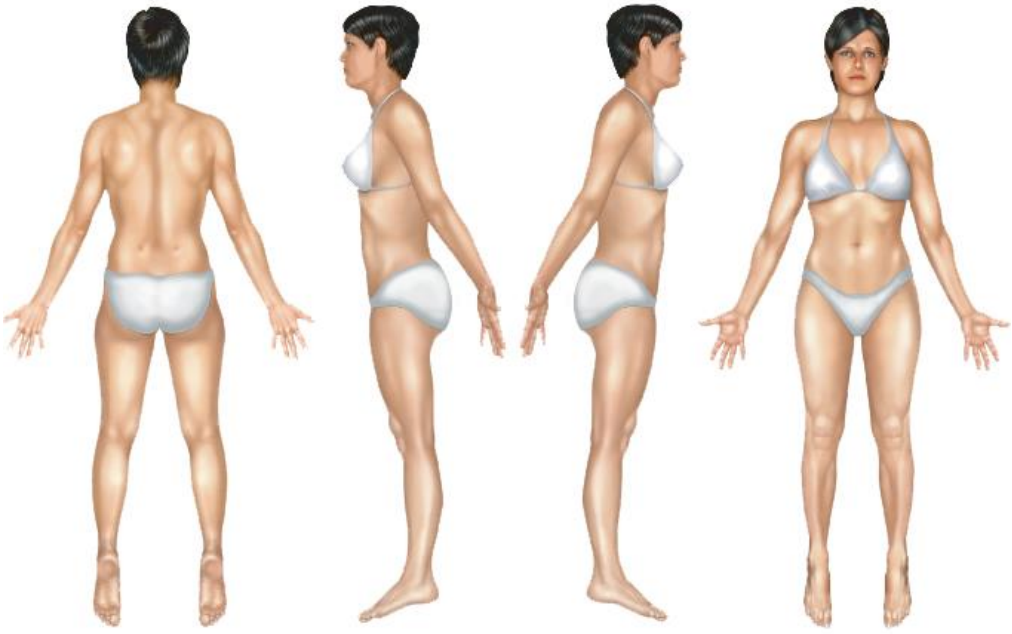
If Male:



Body Diagram: Please indicate on the body where your symptoms are and what type of pain you are experiencing. Use the following to help describe the pain:

N-	Numbness	PN- Pins and Needles
B-	Burning	D-Dull Ache
S-	Stabbing	P- Pain

If Female:



Body Diagram: Please indicate on the body where your symptoms are and what type of pain you are experiencing. Use the following to help describe the pain:

N-	Numbness	PN- Pins and Needles
B-	Burning	D-Dull Ache
S-	Stabbing	P- Pain

Medications:

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

NAME	Start Date	Frequency	Dosage	NAME	Start Date	Frequency	Dosage

List any vitamins, herbs or nutritional supplements that you are taking:

Vitamin/Mineral Name	Year Started (yyyy)	Year Stopped (yyyy)	Dosage (amount/# daily)

Allergies:

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

Brain or Head Trauma:

How many episodes of brain trauma have you had in your life? _____

If 1 or more, please be specific and write down date of occurrence.

Immune System: *Please list all infections over your entire life with the number of each. If none, enter 0.*

Strep Throat		**Mono**	
Pneumonia		**Bronchitis**	
Urinary Tract Infection		**Prostatitis**	
Sinusitis		**Vaginal yeast infection/Jock Itch**	
Gastroenteritis/Traveler's Diarrhea		**Lyme's Disease**	
Colds and flus PER YEAR		**Other Infections**	

Preventive Tests History:

	Month/Year of Last Test	Test Results
Cholesterol		
Bone Density		

Colonoscopy		
Exercise Stress Test		

Review of Systems: Please answer the below

Constitutional		
Neg	Pos	
		Chills
		Fatigue
		Fever
		Malaise
		Night Sweats
		Weight Gain
		Weight Loss
		Other:

Neurological		
Neg	Pos	
		Extremity Numbness
		Extremity Weakness
		Gait Disturbance
		Headache
		Memory Loss
		Seizures
		Tremors
		Other:

Gastrointestinal		
Neg	Pos	
		Abdominal Pain
		Blood in Stool
		Change in Stool
		Constipation
		Diarrhea
		Heartburn
		Loss of Appetite
		Nausea
		Vomiting
		Other:

Hematologic/ Lymphatic		
Neg	Pos	
		Easy Bleeding
		Easy Bruising
		Lymphadenopathy
		Other:

Metabolic/ Endocrine		
Neg	Pos	
		Cold Intolerance
		Heat Intolerance
		Polydipsia
		Polyphagia
		Other:

Cardiovascular		
Neg	Pos	
		Chest Pain
		Claudication
		Edema
		Palpatations
		Other:

Musculoskeletal		
Neg	Pos	
		Back Pain
		Joint Pain
		Joint Swelling
		Muscle Weakness
		Neck Pain
		Other:

Integumentary		
Neg	Pos	
		Breast Discharge
		Breast Lump
		Brittle Hair
		Brittle Nails
		Hair Loss
		Hirsutism
		Hives
		Pruritus
		Mole Changes
		Rash
		Skin Lesions
		Other:

Respiratory		
Neg	Pos	
		Chronic Cough
		Cough
		Known TB Exposure
		Shortness of Breath
		Wheezing
		Other:

Immunologic		
Neg	Pos	
		Contact Allergy
		Environ Allergy
		Food Alleries
		Seasonal Allergies
		Other:

Reproductive		
Neg	Pos	
		Erectile Dysfunction
		Penile Discharge
		Sexual Dysfunction
		Abnormal Pap
		Dysmenorrhea
		Hot Flashes
		Irregular Menses
		Vaginal Discharge
		Other:

HEENT		
Neg	Pos	
		Ear Drainage
		Ear Pain
		Eye Discharge
		Eye Pain
		Hearing Loss
		Nasal Drainage
		Sinus Pressure
		Sore Throat
		Visual Changes
		Other:

Phsyciatric		
Neg	Pos	
		Anxiety
		Depression
		Insomnia
		Other

Genitourinary		
Neg	Pos	
		Dribbling
		Dysuria
		Hematuria
		Polyuria
		Slow Stream
		Urinary Frequency
		Urinary Incontinence
		Urinary Retention
		Other:

Medical History- FEMALE ONLY (IF YOU ARE NOT A MEMBER PLEASE SKIP TO SURGICAL SECTION)

Are you currently pregnant?	☐ Yes ☐ No	First day of last cycle?	
How many pregnancies have you had?		How many children?	
How many miscarriages?		How many abortions?	
Do you perform monthly self breast exams?		☐ Yes ☐ No	
Had a hysterectomy?	☐ Yes ☐ No	If yes, were your ovaries removed?	☐ Yes ☐ No
Has your abdominal girth and weight been increasing?		☐ Yes ☐ No	
Have you had any menstrual irregularities?		If yes, please explain below:	
Are you taking or have you taken hormones or oral contraceptives?		☐ Yes ☐ No	

If yes, please list all hormones and oral contraceptives you have taken below:

Year Started	Year Stopped	List hormones or contraceptives here

Have you ever had any problems or concerns about taking hormone replacement therapy? If yes, explain.

	Month/ Year of last test	Test Results
Pap/pelvic Exam		
Breast Exam		
Mammogram		
Thermography		
Pelvic Ultrasound		

Medical History- FEMALE ONLY (IF YOU ARE NOT A MEMBER PLEASE SKIP TO SURGICAL SECTION)

Check the appropriate box below based on symptom severity with 5 being the most severe.

0=NEVER 5=MOST SEVERE	0	1	2	3	4	5
Hot Flashes						
Night Sweats						
Vaginal Dryness						
Decreased Libido						
Insomnia						
Depression						
Anxiety						
Headaches						
Mood Swings						
Weight Gain						
Bloating						
PMS						
Acne						
Facial Hair Growth						
Brain Fog						

Menstrual History- FEMALE ONLY (IF YOU ARE NOT A MEMBER PLEASE SKIP TO SURGICAL SECTION)

Do you currently have menstrual cycles? ☐ Yes ☐ No

If no, when did they stop?

Are your menstrual cycles: ☐ Regular ☐ Irregular How frequently do you get them? _____

How many days of menstrual flow do you have? _____

Is your flow: ☐ Light ☐ Medium ☐ Heavy

Do you have any of the following symptoms during your menstruation? (check all that apply)

☐ Cramps ☐ Cravings ☐ Insomnia ☐ None ☐ Other _____

Do you have the following symptoms pre-menstrual? (check all that apply)

☐ Bloating ☐ Water Retention ☐ Breast Tenderness ☐ Irritability ☐ Moodiness ☐ Insomnia

☐ Anxiety ☐ Depression ☐ Food Cravings ☐ None ☐ Other _____

Do you have a history of any of the following? (check all that apply)

☐ Ovarian Cysts ☐ Uterine Fibroids ☐ Thyroid Nodule ☐ Fibrocystic Breasts

Surgical History:

Please list any surgeries you have had:

1) _____

2) _____

3) _____

4) _____

5) _____

Family History:

Family History: Do any Family Members have any of the following? Please Indicate who has the condition:

ADD/ADHD_____

Alcoholism _____

Allergies _____

Arthritis _____

Asthma _____

Blood Disorder _____

Cancer _____

Cardiovascular Disease _____

Coronary Artery Disease _____

Depression_____

Developmental Delay _____

Diabetes _____

Eczema _____

Elevated Lipids _____

Genetic Disease _____

Hearing Deficiency _____

Hypertension _____

Irritable Bowel Disease _____

Learning Disability _____

Mental Illness _____

Migraines_____

Obesity _____

Osteoporosis _____

Peripheral Vascular Disease_____

Renal Disease _____

Seizure Disorder _____

Stroke _____

Thyroid Disorder _____

Other _____

Social History:

Have you ever used Tobacco: ___ Yes ___ No If Yes, what type? _____ Frequency: _____

Have you tried to quit using tobacco: ___ Yes ___ No

Do you Drink Alcohol: ___ Yes ____No If Yes: Type of alcohol: _____ Frequency: _____

Amount:_____

Do you drink/consume caffeine: ____ Yes ____No If Yes: Type of caffeine: _____ Frequency: _____

Do you exercise: _____ Yes _____ No Type: _____

Frequency: _____ Special Diet (ex. Gluten free): _____

Have you ever used recreational drugs: ___ Yes ___ No If Yes, please list: _____

Cancellation Policy

We value your time and our provider's time here at Scott Family Health. Therefore, we are strictly enforcing the 24-hour cancellation policy. You may opt-in for e-mails or text reminders that will be given 48 hours in advance. Any appointments must be cancelled at least 24 hours prior to your scheduled appointment to avoid the cancellation fee. The cancellation fee is $35 for all services. We appreciate your understanding.

Patient: _____ Date: _____/_____/_____

Credit Card Authorization for Cancellation

We provide secured methods of accepting your payment if a cancellation is made with less than 24 hours' notice or if an appointment is missed.

We will automatically charge the card on file for $35.00 for any missed appointments or appointments cancelled with less than 24 hours' notice.

I, _____ authorize Scott Family Health to keep my signature and credit card information on file to charge my account $35.00 if signed cancellation policy is violated.

I am authorizing the use of this card for the Scott Family Health cancellation fee when applicable.

*If you choose not to leave a card on file, a bill for $35 will be sent to the address we have listed and will need to be resolved prior to your next visit. Unresolved late fees may result in cancellation of future appointments.

Name of Patient(s): _____ Card #: _____

Card Holder Name: _____ Exp: _____ Security Code: _____

Card Holder Address: _____

Type of Credit Card: VISA _____ MC _____ AMEX _____ DISC _____

Signature: _____

By signing below, I am stating that all of the information above is completed to the best of my knowledge and belief true, correct and complete.

_____ _____

Patient or Guardian Signature Date

_____ _____

Print Name Relationship