INFINITE HEALTH
INTEGRATIVE MEDICINE CENTER

Medicine for the body, mind & soul
www.YourInfiniteHealth.com

Date:_____ Medical Record #_____

Guest Demographics

First Name:_____ Middle Name: _____Last Name: _____
Mailing Address:_____
City, State, Zip:_____
Date of Birth:_____ Age:_____ Gender (Circle One): Male / Female
SSN:_____ Email:_____
Home Phone #:_____ Work Phone #:_____
Cell Phone #:_____ Alternate Phone #:_____
Emergency Contact Name and Number:_____

What type of service are you here for? (Check all that apply):

- ☐ Physician Consultation
- ☐ Hormone/Testosterone/Metabolic Balancing Consultation
- ☐ Weight Loss /Weight Management Consultation
- ☐ Nutrition/Dietary Consultation
- ☐ Fitness/Exercise Consultation
- ☐ Dietary/Nutrition Consultation
- ☐ Personal Empowerment Coaching
- ☐ Energy Healing Therapy/Reiki
- ☐ Meditation/Directed Imagery
- ☐ Yoga Consultation
- ☐ Other:_____

How did you learn about Infinite Health?

- ☐ Another Patient:_____
- ☐ An Individual (non-patient):_____
- ☐ Website/Internet Search
- ☐ Print/Media
- ☐ Physician/Healthcare Provider:_____
- ☐ Other (please specify): _____

Ethnicity / Race (check all that apply):

- ☐ African American/Black
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ American Indian/Alaska Native
- ☐ Caucasian/White
- ☐ Other _____

Education: How many years of education do you have?

- ☐ No high school diploma
- ☐ High school or equivalent diploma
- ☐ Education beyond high school, but have not completed college bachelor's degree
- ☐ College degree
- ☐ Graduate or professional degree

Current employment status:

- ☐ Working full-time
- ☐ Working part-time
- ☐ Not employed due to other responsibilities
- ☐ Retired
- ☐ On medical leave or disabled
- ☐ Unemployed, looking for work
- ☐ Other (please specify): _____

Marital status:

- ☐ Married, spouse in household
- ☐ Married, spouse not in household
- ☐ Living as married
- ☐ Widowed
- ☐ Never married
- ☐ Divorced
- ☐ Separated

Personal Health History & Self Reflection Inventory

Patient Name: _____ Medical Record #: _____

Preferred Pharmacy (Name, location, phone #):_____

Primary Care Provider (if not joining our Primary Care practice)?_____

Please list all physicians that you see. (Please include Mental Health Professionals):

Physician Name	Address	Specialty or condition that is being treated.

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.):

Approximate Dates of Treatment	Name of Therapist or Treatment Facility	Type of Treatment (e.g., Reiki QiGong)	Reason for Treatment	Beneficial Experience?

Current Medical Concerns (e.g., Diabetes, Heart Disease, Hypertension, etc.):

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Past Medical History: List any major past illnesses, hospitalizations (include year or date if known):

Date:	Illness/Hospitalization	Date:	Illness/Hospitalization

Past Surgical History: List any past surgeries (and what year/date).

Date:	Surgery	Date:	Surgery

Past Gyn/Obstetrical History: List any past pregnancies:

Vaginal Births		**Miscarriages/Still Births**	
Caesarians		**Pregnancy Terminations**	
Abnormal PAP Tests		**Other GYN Procedures**	

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High Cholesterol				
Diabetes				
Thyroid disease				

Breast cancer				
Other Cancer--what type?				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health disorder				
Substance Abuse				

Pharmaceuticals and Supplements:
Do you have Medication allergies? ❑ Yes ❑ No If yes, please list:

Please list all prescribed and over-the-counter medications you take regularly. ***Please include all supplements, vitamins or herbal products.***

Medicine/ Supplement including Dose	Frequency	Medicine/ Supplement including Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please outline your use of the following, past or present:

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do others have concern about your usage?
Tobacco:					
Alcohol:					
Recreational Drugs:					
Caffeine:					

Preventive Health: Please provide the dates and documentation when possible.
Do you routinely wear a seat belt? ❑ Yes ❑ No

	Date		Date
Pap/pelvic exam (females)		Tetanus vaccine (specify Td or Tdap)	
Mammogram (females)		Flu vaccine	
Colonoscopy		Pneumonia vaccine	
Test of stool for blood (Stool Guaiac)		Zoster (shingles) vaccine	
Rectal prostate exam (males)		Hepatitis A	
Prostate Specific Antigen (males)		Hepatitis B	

Bone Density (Dexa)		MMR	
Eye exam		Gardesil (HPV vaccine)	
Cardiovascular stress test		Other	

Review of Symptoms: Please check no or yes for the following **current** symptoms (**within past 3 months**):

GENERAL	**Yes**	**No**	**GASTROINTESTINAL**	**Yes**	**No**
Fever			Diarrhea/Constipation		
Sweats at Night			Indigestion/Heartburn		
Hot Flashes			Nausea		
Temperature Intolerance			Blood in Stool		
Excessive Thirst			**GENITOURINARY**		
Fatigue			Pain or Burning on Urination		
Sleep Difficulties			Frequent Urination		
Daytime Sleepiness			Waking to Urinate More Than Once at Night		
Unplanned Weight Change			Excessive Urination		
SKIN			Difficulty Emptying Bladder		
Rash			Urinary Incontinence		
New or Changing Moles			Decreased Sexual Desire		
EYES			Pain With Intercourse		
Pain			Sexually Transmitted Diseases		
Redness			Fertility Issues		
Vision Change			**Men:**		
EAR, NOSE, THROAT			Erectile Dysfunction		
Hearing Loss			**Women:**		
Ringing In Ears			Heavy Vaginal Discharge		
Dizziness or Vertigo			Heavy Menstrual Bleeding		
Bleeding Gums			Painful Menstrual Periods		
Nosebleeds			Irregular Menstrual Bleeding		
BREASTS			**MUSCULOSKELETAL**		
Breast Pain			Generalized Or All-Over Pain		
Masses or Lumps			Joint Pain		
Nipple Discharge			Stiffness		
Skin Changes			Joint Swelling		
CARDIOVASCULAR			Joint Redness		
Chest Pain			Back or Neck Pain		
Heart Murmur			**NEUROLOGICAL**		
Irregular Heart Beat (Palpitations)			Abnormal Gait (Trouble Walking) or Falls		
Leg Swelling or Edema			Headaches Severe and/or Frequent		
PULMONARY			Seizures		
Wheezing or Shortness of Breath			Muscle Weakness, TIA or Stroke		
Chronic Cough			Fainting or Loss of Consciousness		
HEMATOPOIETIC			Localized Numbness, Tingling, Neuropathy		

Swollen Lymph Glands			**PSYCHOLOGICAL**		
Blood Clots			Anxiety		
Excessive Bleeding			Depression		
Anemia			Memory Loss		
			Mood Swings		

Trauma History: Have you ever been the victim of trauma or abuse (Including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster) ? ❑ Yes ❑ No
If yes, is this an active issue in your life that you would like to address while you are here? ❑ Yes ❑ No

_____

_____

Movement, Exercise and Rest:
What forms of exercise and movement do you enjoy?_____
Please describe your usual physical activity:

Activity	How Often	How Long Each Time?

How many hours of sleep do you usually get each night?_____
Describe any issues you have with sleep:_____
_____

Nutrition: Please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Please list everything you ate in the last 24 hours:

Morning:	
Afternoon:	
Evening:	
Snacks:	

Do you currently or have you ever had a problem with weight or eating? ❑ Yes ❑ No
If yes, please describe:_____
Are you comfortable with your relationship with food? ❑ Yes ❑ No
Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No
Who prepares your meals?_____

Personal and Professional Development:
Current or past occupation: _____
❑ Retired? ❑ Working at Home? ❑ Care-taking? ❑ Disabled? ❑Unemployed?
Are you happy with your occupation? (Circle One): Yes / No
Why or why
not?_____
_____

Do you anticipate any work changes in the near future? Retirement, Etc.: _____
_____

Do you have a Racial/Culture heritage that is important to you? _____
_____

Relationships:
Relationship status: _____ If married or partnered, what is your relationship length? _____
What are your living arrangements?_____ Number of children and ages: _____
Are you sexually active? ❑ Yes ❑ No Are you happy with your sexual life? _____
Which relationship(s) fulfill and/or empower you?_____
Who or what drains your energy?_____

Physical Environment:
Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?
_____
Have you had hazardous environmental or occupational exposures? If yes, please describe.
_____

Spirituality:
What things or activities bring you your greatest joy and meaning? What inspires you?
_____
_____
What things create the greatest challenges for you? _____
_____
What makes you feel connected to the larger world? Describe your spiritual or religious practices if any (I.E., Meditation, Prayer, Time in Nature, Worship Attendance, Etc.)._____
_____
If time and money were not an issue, describe the things you long to do in your life:_____
_____
_____

Mind-Body Connection:
Rate the amount of stress in your life: □ None □ A Little Bit □ Moderate □ Quite a Lot □ Extreme
How well do you manage stress? □ Not at All □ A Little Bit □ Moderate □ Quite well □ Excellent
What are the main sources of stress in life? (Personal, Professional, Financial, Etc.) _____
_____
What are your methods of coping with the stress in your life?_____
_____

What are your health goals? What are your overall goals for improving your health and your life?_____
_____
_____
_____
_____
Is there anything else that would be helpful for us to know about you?_____
_____
_____

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Client Agreement and Waiver With Brief Medical History

In our commitment to support your health and well being, before using our facility, we would like to learn a little about your medical history.
Date:_____

Name:_____
Mailing Address:_____
City_____ State_____ Zip_____
Phone: (W) _____ (H) _____ (C)_____
Email address: _____

Please Circle "Yes" or "No" To the Following Questions:

1. Has your doctor ever said you have heart trouble? YES / NO
2. Do you frequently have pains in your heart and chest? YES / NO
3. Do you often faint or have spells of severe dizziness? YES / NO
4. Has a doctor ever said your blood pressure was too high? YES / NO
5. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse by exercise? YES / NO
6. Is there any good physical reason not mentioned here why you should not follow an activity program even if you wanted to? YES / NO
7. Are you over age 65 and not accustomed to vigorous exercise? YES / NO

Client Agreement/Waiver

The undersigned client agrees to abide by the guidelines of Infinite Health Integrative Medicine Center, including the completion of the above medical questionnaire.

The undersigned client agrees that all use of Infinite Health Integrative Medicine Center's facilities, services and programs shall be undertaken at his/her sole risk and Infinite Health Integrative Medicine Center shall not be liable for any injuries, accidents or deaths occurring to clients arising either directly or indirectly out of utilizing Infinite Health Integrative Medicine Center's facilities, services and programs. The client, for himself/herself herself and on behalf of his/her executors, administrators, heirs and assigns, does herby expressly release, discharge, waive, relinquish, and covenants not to sue Infinite Health Integrative Medicine Center, its officers and agents for such claims, demands, injuries, damages or cause of action, with respect to use of Infinite Health Integrative Medicine Center's facilities, programs and services.

The undersigned Infinite Health Integrative Medicine Center client declares that they have completed the medical questionnaire above as required by Infinite Health Integrative Medicine Center and that they declare they are physically able to participate in physical activity and or utilize whirlpools and dry/wet sauna rooms. Furthermore, Client declares that Infinite Health Integrative Medicine Center has advised client to obtain a medical clearance in the event they answer yes to any of the medical history questions, or they are unsure of their physical health and that client maintains that he/she is physically capable of pursuing physical activity in Infinite Health Integrative Medicine Center without such steps being taken or has done so.

Client Signature:_____ Date:_____

Infinite Health Integrative Medicine Center
Lake Charles, LA 70601
Phone: 337.312.8234
Facsimile: 337.312.8411

Patient Name:_____
Date of Birth:_____
Medical Record Number:_____

Authorization for Release of Medical Information

THIS FORM MUST BE COMPLETED IN FULL

(Please fill out a separate form for each doctor or hospital request to release information)

I authorize and request: _____
(Name of doctor or hospital **RELEASING** information)

_____
(Address)

_____
(Telephone #) (Fax #)

Release to: _____**Dr. Trip Goolsby of Infinite Health Integrative Medicine Center**_____
(Name of doctor or hospital to **RECEIVE** information)

The following information for the **dates of service** from _____ through _____.

Information to be released (check all that apply)**:**
___ ENTIRE Record ___ Office Visit Note(s) ___ Procedure Note(s)
___ Laboratory Reports ___ Radiology Reports ___ Immunization Records
___ Other: _____
___ Medical information pertinent to treatment for alcohol, drug abuse, or psychological assessment and/or treatment for the periods from _____ through _____.

Purpose of this release (Check all that apply):
___ Continuation of Care ___ Insurance processing ___ Legal ___ Personal use
___ Other (specify): _____

I Understand That:

- ***The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).***
- Without my express revocation, this Authorization will automatically ***expire*** one year from the date signed below, unless I request an expiration date less than one year.
- I may ***revoke*** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
- Information disclosed pursuant to the authorization may be subject to ***re-disclosure*** by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Note: The patient is responsible for any charges incurred in relation to this request of records.
Signature: My signature is required to validate this Authorization. If I do not sign this authorization, Infinite Health Integrative Medicine Center will still provide treatment and seek payment for services provided.

This authorization will expire on _____(date).

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Legal Representative (if applicable)* Relationship to Patient

*If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor Patient's behalf. By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

The information in this Fax may contain sensitive, protected health information intended only for the addressee(s). Any other person, including anyone who believes he/she might have received it due to an addressing error, is requested to notify the sender immediately by return Fax 337.312.8411, and to shred it without further reading or retention. The information is not to be forwarded to or shared unless in compliance with IHIMC policies on confidentiality and/or with the approval of the sender.