NORTH FLORIDA
INTEGRATIVE MEDICINE

Patient Information

Full Name (First, MI, Last) _____

Current Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ SSN _____

Work Phone _____ Birth Date _____

Email Address _____

Preferred Pharmacy _____

Insurance Information

(*Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service.*)

Patient's ID # _____

Insurance Company _____

Subscriber's Full Name (First, MI, Last) _____

Relationship to Subscriber _____ Subscriber's SSN_____

Current Address _____

City _____ State _____ Zip Code_____

Subscriber's Birth Date _____ Subscriber's Employer _____

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Family Information

Marital Status □ Single □ Married □ Other

Employment Status □ Employed □ Unemployed □ Student

Employed by _____ Position _____

Emergency Contact _____ Contact Number _____

Relationship _____

I hereby authorize North Florida Integrative Medicine and its team members to release any billing information to “Party Responsible for Payment.”

Patient’s Signature _____ **Date** _____

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New Patient History and Questionnaire

Section 1: Please list any and all symptoms that you have had in the past 4 weeks

Section 2: Please list any and all medical problems and surgeries

Section 3: Fill out your social history, habits, and family history

Section 4: Please list all medications (including supplements), doses, and frequency

Section 5: Fill out our Food and Health Survey to help us discover your daily habits

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Section 1: Symptoms

Ears/Nose/Throat System _____

Upper Respiratory System _____

Cardiac System _____

Gastrointestinal System _____

Uro-genital System _____

Musculoskeletal System _____

Skin System _____

Neurological System _____

Psychological/Emotional System _____

Endocrine System _____

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Section 2: Medical History

List all past medical issues/chronic problems:

_____

_____

_____

List all past medical or surgical procedures and dates:

_____

_____

_____

Section 3: Social History

Tobacco Habits

Do you currently use tobacco? _____ How much? _____

If previously used, when did you quit? _____

How many years have you smoked? _____

Alcohol Habits

Do you currently consume alcohol? _____ If NO, when did you quit? _____

How many alcoholic beverages do you consume daily? _____

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Other History

Do you currently use or have you ever injected any recreational drugs? _____

Do you have any HIV or Hepatitis risk factors? _____

Do you have a living will? _____ Do you have a medical power of attorney? _____

Family History

Father – Alive/Dead? _____ Age? _____ Illnesses/Risk Factors: _____

Mother – Alive/Dead? _____ Age? _____ Illnesses/Risk Factors: _____

Other Family Risk Factors: _____

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Section 4: Current Medications and Supplements

Allergies _____

Medication or Supplement Name	Current Dosage (in mg, grams, units, etc…)	When do you take it? (Frequency)
EXAMPLE: TYLENOL	500 MG (extra-strength)	Daily: 2 pills at 8 AM and 10 PM Daily
EXAMPLE: MAGNESIUM	250 mg (Mag Glycinate)	Daily: 2 capsules at 10 PM

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Section 5: Food and Integrative Health Survey

Instructions: For "If YES, how often," list one of the following:

1. FREQUENT/DAILY (once a day)
2. OFTEN (several times a week)
3. SOMETIMES (once a week or less)
4. SELDOM (once or twice a month or less)
5. NEVER (complete avoidance)

Diet currently followed or write NONE: _____

How long have you followed it? _____

Past diets tried: _____

Food allergies: _____

Alcoholic beverages? _____ If YES, how often? _____

Eat out at restaurants? _____ If YES, how often? _____

Consume white flour? _____ If YES, how often? _____

Consume sugar? _____ If YES, how often? _____

Consume artificial sweeteners? _____ If YES, how often? _____

Consume sweetened drinks (incl. soda)? _____ If YES, how often? _____

Use vegetable oils (e.g., canola)? _____ If YES, how often? _____

Use margarine or butter substitutes? _____ If YES, how often? _____

Consume packaged foods? _____ If YES, how often? _____

Consume coffee or caffeinated products? _____ If YES, how often? _____

Consume iodized salt (table salt)? _____ If YES, how often? _____

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Overall Health

Stress

How would you describe your stress levels (at work, at home)? _____

What stress management strategies do you use? _____

Sleep

Average hours of sleep per night: _____

Average sleep quality: _____

Do you snore? _____ Trouble staying asleep? _____

Trouble falling asleep? _____ Have a sleep routine? _____

Electronics in the bedroom? _____

Movement

Do you regularly exercise? _____ If YES, how often? _____

What kind of exercise(s)? _____

Estimate how long you sit daily (in hours): _____

Toxins

Are you exposed to environmental toxins? _____ If YES, what kind? _____

Have you been exposed in the past? _____ When? _____ What kinds? _____

How long? _____