Patient Information

Full Name (First, MI, Last) _____

Current Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ SSN _____

Work Phone _____ Birth Date _____

Employed by _____ Position _____

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 _____

Relationship to Subscriber _____ Subscriber's SSN _____

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

Current Address _____

City _____ State _____ Zip Code _____

Subscriber's Birth Date _____ Subscriber's Employer _____

Family Information

Marital Status □ Single □ Married □ Other

Employment □ Employed □ Unemployed □ Student

Employed by _____ Position _____

Emergency Contact _____ **Emergency 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 _____

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**

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 _____

Section 2: Medical History

List all past medical issues/ chronic problems:

_____

_____

_____

List all past medical or surgical procedures and concurrent dates:

_____

_____

Section 3: Social History

Tobacco Habits

Do you currently use tobacco? _____ How much do you consume? _____

If you previously used tobacco, when did you quit? _____

How many years did you smoke for? _____

Alcohol Habits

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

How many alcoholic beverages do you consume daily? _____

Other History

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

Do you have any HIV or Hepatitis risk factors (including IV drug use, homosexual intercourse, and blood transfusion, intercourse with a drug user or prostitute)? _____

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

Family History

Father: Is he alive or dead? _____ Current age or age of death? _____

Please list all illnesses or risk factors below

_____

_____

Mother: Is she alive or dead? _____ Current age or age of death? _____

Please list all illnesses or risk factors below

_____

_____

Other Family: Please list any relevant risk factors below

_____

_____

Section 4: Current Medications and Supplements

Allergies _____

Medication or Supplement Name	Current Dosage (in mg, grams, units, etc…)	When do you take it? (Frequency)
1. *EXAMPLE: TYLENOL* 2. *EXAMPLE: MAGNESIUM*	*500 MG (extra-strength)* *100 mg (Mag Glycinate)*	*Daily: 2 pills at 8 AM and 10 PM* *Daily: 4 capsules at 10 PM*

Section 5: Food and Integrative Health Survey

INSTRUCTIONS: For the "If YES, how often" section, please 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)**

Please describe what diet you currently follow or write NONE _____

If YES, how long have you been following it? _____

What diets have you tried in the past? _____

_____

Please indicate any *food allergies* you are aware of_____

_____

Do you consume alcoholic beverages? _____ If YES, how often? _____

Do you eat out at restaurants? _____ If YES, how often? _____

Do you consume white flour? _____ If YES, how often? _____

Do you consume sugar? _____ If YES, how often? _____

Do you consume artificial sweeteners? _____ If YES, how often? _____

Do you consume sweetened drinks (incl. soda) _____ If YES, how often? _____

Do you use vegetable oils (i.e. canola)? _____ If YES, how often? _____

Do you use margarine or butter substitutes? _____ If YES, how often? _____

Do you consume packaged foods? _____ If YES, how often? _____

Do you consume coffee or caffeinated products? _____ If YES, how often? _____

Do you consume iodized salt (table salt)? _____ If YES, how often? _____

Dietary Habits (Please describe an average day of eating with accuracy and honesty)

Describe a typical breakfast and time _____

Morning snacks or beverages_____

Describe a typical lunch and time _____

Afternoon snacks or beverages_____

Describe a typical dinner and time _____

Nighttime snack or dessert _____

Overall Health

Stress

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

What stress management strategies do you use? _____

Sleep

On average, how many hours or sleep do you get? _____

How would you describe your average sleep quality? _____

Do you snore? _____ Do you have trouble staying asleep if you wake up? _____

Do you have trouble falling asleep? _____Do you have a sleep routine? _____

Do you have electronics in your bedroom? _____

Movement

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

What kind of exercise(s) do you perform? _____

Estimate how often you sit for throughout the day (in hours)? _____

Toxins

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

Have you been exposed to environmental toxins in the past/ when? _____

What kinds of toxins? _____ How long? _____