

Demographic & Insurance Information

Name:			Phone:						
Age:	DOB:	Sex:	Phone (2):						
Marital Status	:		SSN:						
Address:									
 Email:									
	Relationsh	Relationship to Patient:							
insurance billir co-insurances,	ng service for you. or other fees to pro e, we will provide	A \$3.00 insurance bit vide this service for y	illing fee will be charged per you. If verification has not b	business days) prior to providing r visit in addition to any co-pays, been completed ahead of your apasurance company and waive the					
			ormation (primary)						
			of Primary: -	DOB:					
			·						
Incurance Nar	ma:		rmation (secondary)						
Plan Name									
				DOB:					

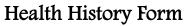




Name:	DOB:	Date:
Guarantor (perso	on who is financially resp	oonsible):
Name:		
Phone:		
Address:		
Email:		
Relationship to Patient:		
Financial	Responsibility Agreemer	nt
<i>Please initial each statement on the line provided</i> I understand and agree to the following genera		g on the lines at the bottom of the page.
 I am responsible as the patient or patient 's including office visit fee, in-office lab test or ances from previous visits/ services, and the your insurance)	procedures, medications adminice \$3.00 insurance billing fee (if and thorough documentation requible for all charges. If it become the undersigned agrees to pay force Tranquil Healing Center to release to insurance billing: The needs to insurance billing: The needs to insurance benefit the rand is NOT a guarantee of pays can require presentation of pays be re-verified for specific covered to fall insurance co-pays, deductor paid by my insurance carrier. In a paid by my insurance carrier of Dr. Terra Sowinski. This release ased for any other reason without there in.	istered, send-out labs, outstanding bal-Tranquil Healing Center,PS is billing uired to support any discounts I am a necessary to effect collections of any or all costs and expenses, including ease information necessary to secure celled within 24 hours of the appoint-to fulfill this responsibility sis used to determine if there is coverayment by my insurance carrier roof of insurance at any time rage details as often as every six uired to verify my insurance coverage tibles, and co-insurance balances due, y of my financial responsibilities or doctand assign all benefits for unpaid serse applies to support of the insurance ut written consent of the patient sibility, and by signing below, agree
Printed Name: (patient 18yo or older)	Guarantor Printed Name	:
Signature:	Guarantor Signature:	
Initials: Date:	Initials:	Date:



Name:	Г	OOB:	Date:			
Drug Allergies:						
	Current Med Il medications you are cur to include all over the co	rently using or ha				
Drug Name	Reason for Use	Dose	How Long?	Prescriber		
Please list all v	Current Supp itamins. Minerals herbs, an currently using or hav	nd other natural p	roducts you are			
Product Name	Reason for Use	Dose	How Long?	Prescriber		



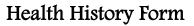


Name:			_ DOB: _			Date	e:		
Height:	Weight:	_ Wt.	. 1 year a	igo: _		Max Wt.			
What health cond	cerns would you like	Dr. Terra to	help yo	u with	า? :				
-	tment: level to your l			_	=		will take you to get		
Did your mother		Early Heal tg her pregi		•	u? Y	'es	No		
If yes, please des	cribe:								
Please check if yo□ frequent ear in □ bronchitis	breast fed? ou have had any of the nfections	he following lic eumonia	g childha	od illi D ed D m	nesse: czema nening	5: 1	□ recurrent colds □ other		
		Immuni	zations						
Did you receive s	not to be vaccinated standard immunization a copy of your immu	ns?	ecord.			Yes	□ No		
	ce any adverse reacti t was the reaction? _			tions?		Yes	□ No		
Do you receive a	regular influenza vac	ccination?				Yes	□ No		
Do you have any	additional immuniza	tions? (if ye	es, please	e list)		Yes	□ No		



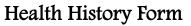


Name:			DOB: _	Date:
			Health Procedur	res:
	_	d the follow	ing health maintenance p	procedures within the last 5 years, and please
provide dat				
□ Full Phy	sical Exam	date:	Findings?	
□ Dental E	Exam	date:	Findings?	
☐ Choleste	erol Check	date:	Findings?	
\square CBC, Chen	nistry, thyroid	date:	Findings?	
□ Colonos	сору:	date:	Findings?	
□ Eye Exa	m:	date:	Findings?	
□ EKG:		date:	Findings?	
□ DEXA (b	oone density):	date:	Findings?	
□ PAP (f) ,	/ Prostate (m):	date:	Findings?	
□ Mammo,	/ thermogram:	date:	Findings?	
□ Other:		date:	Findings?	
\square Other: _	·	date:	Findings?	
□ Other: _		date:	Findings?	
			Surgeries	
Date	Procedure		Reason	Outcome
			Hospitalization	าร
Date	Reason			Outcome
	-			
				<u> </u>
	<u> </u>			



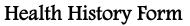


Name:									DOB:				C	oate: _				
									of Systems									
									cle all that apply.									
Y = present co	nditi	on)	N = never h	ad	the	e c			' =	p	as	t proble	m	F = Far	nily	me	mber
									General									
Dizziness	ΥN	Р	F	Night Sweats	<u>Y</u>	<u>N</u> I	P	F	Fatigue	'	<u> </u>	۱ I	P F					
									Head:									
Headaches	ΥN	Ρ	F	Migraines	Υ	N I	Р	F	Jaw/ TMJ	`	ΥI	N F	PF	Vision		Υ!	ΝP	F
Hearing	ΥN	Ρ	F	Smelling	Υ	N I	Р	F	Tasting	`	ΥI	N F	P F	Denta	I	Υ!	ΝP	F
									Skin									
Rashes	ΥN	Р	F	Eczema, hives	Υ	N I	Р	F	Color Changes	,	/ I	N F	P F	Moles		Υ	ΝP	F
Skin Cancers	ΥN			, ,					J									
								Mus	culoskeletal									
Joint pain	ΥN	Р	F	Muscle spasm	Υ	N I	Р	F	Weakness	`	/ I	N F	P F	Break	s/ Sprains	Υ	ΝP	F
								N	eurologic									
Fainting	ΥN	Р	F	Numb/ tingling	Υ	N I	Р		Weak muscles	,	ΥI	N F	P F	Seizui	es	Υ	ΝP	F
Paralysis	ΥN			Loss of memory									P F					
,				<u> </u>					Emotional									
Mood swings	ΥN	Р	F	Nervousness	Υ	N I	P		Tension/ stress	,	/ I	N F	⊃ F	Anxiet	V	Υ	ΝP	F
Depression	ΥN				-			-					•		,			
- тр. остолог								E	Indocrine								-	
Excessive Thirst	ΥN	Р	F	Cold intolerance	Υ	N I	Р		Thyroid issues	,	ΥI	N F	P F	Diabe	tes	Υ	ΝP	F
Excessive hunger				Heat intolerance					,									
									cular / Respiratory									
Cough	ΥN	Р	F	Short of Breath	Υ	N I	Р	F	Asthma	`	ΥI	N F	P F	Chest	Pain	Υ!	ΝP	F
Abdominal pain	ΥN	Р	F	Blood clots	Υ	N I	Р	F	Heart disease	`	ΥI	N F	P F	Low /	high BP	Υ!	ΝP	F
								Gas	trointestinal									
Diarrhea	ΥN	Ρ	F	Constipation	Υ	N I	Р	F	Abdominal pain	`	ΥI	N F	P F	Blood	in stool	Υ	ΝP	F
Nausea /Vomiting	ΥN	Р	F	BM per day				_										
				· · · · ·					Urinary									
Incontinence	ΥN	Ρ	F	Infections	Υ	ΝI	Р	F	Painful urination	۱ ۱	Y I	N F	P F	Stone	S	Υſ	ΝP	F
									Males									
Hernias	ΥN	Р	F	Testicular mass	Υ	N I	Р	F	Sexual difficulty	`	/ I	N I	D	Traum	na / injury	Y	ΝP	
A				A I	_				Female	•					De :	nı.	atta i	
Age of 1st Menses Number of Pregna				Age last Mense Number of live B						•					Duration I Number of			S
Birth Control	YNI		If ye						Number of		Ju			w long?	. 10.11001			





Name:	DOB:	Date:
Lifestyle	Habits	
Please provide the following information:		
Do you smoke? □ yes □ no Have you	ever? □ yes □	no
If yes, Packs per day?	-	
Smoker in your household? □ yes □ no		
Do you use recreational drugs? □ yes □ no	If yes, please list: _	
Former drug use?		
Alcohol Use: □ none Type:		
, i		
Job: Satisfaction: □	Excellent □Good	□ Fair □ Poor
Vacation Frequency: # per year Trav		
Do you have occupational health risks? yes		
If yes, please list:		
-		
Sleep Schedule: Time to bed Ti	me to wake	Naps
Sleep Quality: □ well rested □tired who	en waking 🔲 aw	ake during night
☐ sleep in total dark ☐sle	eep with some light in	n the room
Have you experienced physical, emotional, sexual	or verbal abuse?	□ yes □ no
Is your sex life satisfactory? □ yes □ no		
My stress level is:		
Minor □ 1 □ 2 □ 3 □ 4 □ 5	□6 □7 □8	□ 9 □ 10 Severe
My main stressors in life are:		
I relieve stress by:		
The things I do to support my health are:		
The health obstacles that I have are:		





Name:				_ DOB:	Da	te:	
	En	vironme	ental Sens	itivities/ ex	posures		
Do you have adv	erse reaction	ons to any	y of the follo	owing:	•		
Odors:	□ yes	□ no	reaction: _				
Smoke:	□ yes	□ no	reaction: _				
Soap:	□ yes	□ no	reaction: _				
Fumes:	□ yes	□ no	reaction: _				
Perfumes:	□ yes	□ no					
Dust:	□ yes	□ no	reaction: _				
Grasses:	□ yes	□ no					
Pollen:	□ yes	□ no	reaction: _				
Animals:	□ yes	□ no					
Mold:	□ yes	□ no					
Have you been e	xposed to	chemicals				□ no	
If yes, which	ch ones?: _						
Have you been e	xposed to	□ yes	□ no				
If yes, which	ch ones?: _						
Do you have mul	ltiple electr	onic devi	ces in your b	pedroom?	□ yes	□ no	
Do you live near	power line	s or a pov	wer substati	on?	□ yes	□ no	
Please provide ar	ny addition			nformatior ou would like		to know :	
By signing below I co Tranquil Healing Ces to me only (or the pas	nter, PS and I	Dr. Terra So	owinski permiss	sion to use this in	nformation to a	ssist in providing he	althcare
Signature						Date	
Printed Name							