

Demographic & Insurance Information

		Phone:		
OB:	Sex:	Phone (c)	:	
		SSN:		
Email:				
Address:				
Relationship	to Patient:			
	SSN	of Primary:		DOB:
I	nsurance Info	ormation (seco	ndary)	
	Email:	COB: Sex: Email: Address: Relationship to Patient: enter, PS requires a copy of your of need this information for other period date insurance information with Insurance Info Insurance Info	OB: Sex: Phone (c) SSN: Email: Address: Relationship to Patient: enter, PS requires a copy of your valid insurance car need this information for other purposes such as or o date insurance information with our office. Thank y Insurance Information (print SSN of Primary: Insurance Information (second)	

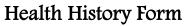




Name:	DOB:	Date:
Guarantor (perso	on who is financially re	sponsible):
Name:	DOB:	Gender: M F other
Phone:		
Address:		
Email:		
Relationship to Patient:		
Financial	Responsibility Agreem	ent
Please initial each statement on the line provided	in addition to signing and dati	ng on the lines at the bottom of the page.
 I am responsible as the patient or patient's general including office visit fee, in-office lab test or ing balances from previous visits/ services. I am responsible for providing all accurate a receiving. I acknowledge that I am financially respons amount owed on this or subsequent visits, t sonable attorney fees. I hereby authorize Transcriptions 	r procedures, medications adn ————— and thorough documentation sible for all charges. If it become	required to support any discounts I am mes necessary to effect collections of any for all costs and expenses, including rea-
 I am financially responsible for a flat fee for pointment time and date, and will keep an u 		-
 I understand and agree to the following with re I understand that Tranquil Healing Center, I am responsible for providing all accurate a and / or bill my insurance carrier. Tranquil Healing Center, PS provides an investigation. 	PS can require presentation of and thorough documentation	required to verify my insurance coverage
assistance or documentation for submission I have fully read and understand the above to abide by and authorize the actions stat	n to my insurance company statements of financial respo	
Printed Name: (patient 18yo or older)	Guarantor Printed Nan	ne:
Signature	Guarantor Signature:	
Signature:	Initials:	

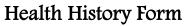
Health History Form

Name:		D	OOB:	Date:	
Drug Allergies	·· ·				
_					
_					
_					
		Current Med I medications you are curr to include all over the col	rently using or hav		
Drug	g Name	Reason for Use	Dose	How Long?	Prescriber
	Please list all vi	Current Supp tamins. Minerals herbs, ar currently using or have	nd other natural p	roducts you are	
Produ	ct Name	Reason for Use	Dose	How Long?	Prescriber



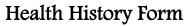


Name:			DOB:		Date	2:
Height:	Weight:	W	/t. 1 year ag	go:		Max Wt
What health c	oncerns would you	like Dr. Terra t	to help you	with? :		
	nmitment: level to y		J	•		will take you to get
	ner have problems describe:	during her pre	-	you?		No
_	□ breast fed? f you have had any	_				mo / yr
□ frequent ea	ar infections	□ colic		□ eczema	а	☐ recurrent colds
□ bronchitis Were you on	frequent or prolong	•		□ mening □ Yes	gitis	□ other □ No
		lmmur	nizations			
	sen not to be vacci			_	.,	-
,	e standard immun		rocord	Ц	Yes	□ No
Did you exper	le a copy of your I rience any adverse what was the reaction	reactions from	immunizati		Yes	□ No
	e a regular influenz				Yes	□ No
Do you have a	any additional imm	unizations? (if y	yes, please	list) 🗆	Yes	□ No



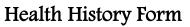


Name:			DOB:	Date:
			Health Procedures:	:
Please check	k if you have had	the followi	ing health maintenance proc	edures within the last 5 years, and please
provide date	es.			
☐ Full Phys	sical Exam	date:	Findings?	
□ Dental E	xam	date:	Findings?	
□ Choleste	rol Check	date:	Findings?	
☐ CBC, Chemi	istry, thyroid	date:	Findings?	
□ Colonos	сору:	date:	Findings?	
□ Eye Exan	n:	date:	Findings?	
□ EKG:		date:	Findings?	
□ DEXA (bo	one density):	date:	Findings?	
□ PAP (f) /	Prostate (m):	date:	Findings?	
□ Mammo/	thermogram:	date:	Findings?	
□ Other:		date:	Findings?	
□ Other:		date:	Findings?	
□ Other:		date:	Findings?	
			Surgeries	
Date	Procedure		Reason	Outcome
				
			Hospitalizations	
Date	Reason			Outcome



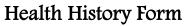


Name:					DOB:		Date:	
					w of Systems			
					ircle all that apply.			
Y = present co	nditio	n	N = never h	ad the cor		= past p	oroblem F = Fa	mily member
					General			
Dizziness	YNF	P F	Night Sweats	YNPF	Fatigue	YNP	-	
					Head:			
Headaches	YNF	PF	Migraines	YNPF	Jaw/ TMJ	YNPI	Vision	YNPF
Hearing	YNF	PF	Smelling	YNPF	Tasting	YNP	F Dental	YNPF
					Skin			
Rashes	YNF	ΡF	Eczema, hives	YNPF	Color Changes	YNPI	F Moles	YNPF
Skin Cancers	YNF		, 00		oois: onangeo			
				Mu	sculoskeletal			
Joint pain	YNF	P F	Muscle spasm	YNPF	Weakness	YNPI	F Breaks/ Sprains	YNPF
					Neurologic			
Fainting	YNF	PF	Numb/ tingling	YNPF	Weak muscles	YNPI	Seizures	YNPF
Paralysis	YNF	P F	Loss of memory	YNPF	Neuropathy	YNPI	=	
					Emotional			
Mood swings	YNF	P F	Nervousness	YNPF	Tension/ stress	YNPI	- Anxiety	YNPF
Depression	YNF	PF					·	
					Endocrine			
Excessive Thirst	YNF	PF	Cold intolerance	YNPF	Thyroid issues	YNPI	F Diabetes	YNPF
Excessive hunger	YNF	PF	Heat intolerance	YNPF				
				Cardiovas	scular / Respiratory			
Cough	YNF	PF	Short of Breath	YNPF	Asthma	YNP	Chest Pain	YNPF
Abdominal pain	YNF	PF	Blood clots	YNPF	Heart disease	YNP	Low / high BP	YNPF
				Ga	strointestinal			
Diarrhea	YNF	PF	Constipation	YNPF	Abdominal pain	YNPI	F Blood in stool	YNPF
Nausea /Vomiting	YNF	PF	BM per day					
					Urinary			
Incontinence	YNF	PF	Infections	YNPF	Painful urination	YNP	Stones	YNPF
					Males			
Hernias	YNF	P F	Testicular mass	YNPF	Sexual difficulty	YNP	Trauma / injury	YNP
					Female			D
Age of 1st Menses Number of Pregna			Age last Mense Number of live I					Bleeding of Abortions
Birth Control	YNP	If yes	s, what type?			ooainage	How long?	





Name:	DOB:	Date:
Lifest	yle Habits	
Please provide the following information:		
Do you smoke? □ yes □ no Have If yes, Packs per day?		
Smoker in your household? □ yes □	no	
Do you use recreational drugs? □ yes □	no If yes, pl	lease list:
Former drug use? $\hfill \square$ yes $\hfill \square$	no If yes, pl	lease list:
Alcohol Use: □ none Type:	Amou	unt/ frequency:
Job: Satisfaction: Vacation Frequency: # per year Do you have occupational health risks? □ ye If yes, please list:	Travel frequences □ no	cy: # per year
Sleep Schedule: Time to bed Sleep Quality: □ well rested □tired □ sleep in total dark	when waking	□ awake during night
Have you experienced physical, emotional, sex ls your sex life satisfactory? □ yes □ no	kual or verbal a	abuse? 🗆 yes 🗖 no
My stress level is: Minor		
The health obstacles that I have are:		





Name:				_ DOB:	Da	te:
	En	vironm	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	reaction:			
Pollen:	□ yes	□ no	reaction:			
Animals:	□ yes	□ no				
Mold:	□ yes	□ no	reaction:			
Have you been e	xposed to	chemicals	, now or in	the past?	□ yes	□ no
If yes, whic	ch ones?: _					
Have you been e	xposed to	heavy me	tals, now or	in the past?	□ yes	□ no
If yes, whic	ch ones?: _					
Do you have mul	tiple electr	onic devi	ces in your l	pedroom?	□ yes	□ no
Do you live near	power line	s or a po	wer substati	on?	□ yes	□ no
Please provide ar	ny addition			nformatior ou would like		to know :
	nter, PS and I	Dr. Terra So	owinski permiss	sion to use this in	nformation to a	of my knowledge. I give ssist in providing healthcar ompany if requested.
 Signature						Date
Printed Name						