TRANQUIL Healing Center

Demographic & Insurance Information

Name: _____ Phone: _____

Age: _____ DOB: _____ Sex: _____ Phone (c): _____

Marital Status: _____ SSN: _____-_____-_____

Address: _____

_____

Email: _____

Emergency Contact: _____ Phone: _____

Email: _____

Address: _____

_____

Relationship to Patient: _____

Tranquil Healing Center, PS requires a copy of your valid insurance card and photo ID. We do not direct bill insurance, however, may need this information for other purposes such as ordering images or labs. It is your responsibility to maintain up to date insurance information with our office. Thank you. .

Insurance Information (primary)

Insurance Name: _____

Subscriber #: _____

Group #: _____

Plan Name: _____

Insured Name: _____

Relationship: _____ SSN of Primary: _____-_____-_____ DOB: _____

Insurance Information (secondary)

Insurance Name: _____

Subscriber #: _____

Group #: _____

Plan Name: _____

Insured Name: _____

Relationship: _____ SSN of Primary: _____-_____-_____ DOB: _____

TRANQUIL Healing Center

Financial Agreement

Name: _____ DOB: _____ Date: _____

Guarantor (person who is financially responsible):

Name: _____ DOB: _____ Gender: M F other

Phone: _____ SSN: _____-_____-_____

Address: _____

Email: _____

Relationship to Patient: _____

Financial Responsibility Agreement

Please initial each statement on the line provided in addition to signing and dating on the lines at the bottom of the page.

I understand and agree to the following general responsibilities:

- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including office visit fee, in-office lab test or procedures, medications administered, send-out labs, and outstanding balances from previous visits/ services. _____
- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving. _____
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Tranquil Healing Center to release information necessary to secure payment. _____
- I am financially responsible for a flat fee for any appointment not cancelled within 24 business hours of the appointment time and date, and will keep an up to date credit or check card on file to fulfill this responsibility. - _____

I understand and agree to the following with regards to insurance billing:

- I understand that Tranquil Healing Center, PS can require presentation of proof of insurance at any time._____
- I am responsible for providing all accurate and thorough documentation required to verify my insurance coverage and / or bill my insurance carrier. _____
- Tranquil Healing Center, PS provides an invoice/ superbill at the time of service only and will not provide further assistance or documentation for submission to my insurance company. _____

I have fully read and understand the above statements of financial responsibility, and by signing below, agree to abide by and authorize the actions stated there in.

Printed Name:_____ (patient 18yo or older) Guarantor Printed Name: _____

Signature: _____ Guarantor Signature: _____

Initials: _____ Date: _____ Initials: _____ Date: _____

TRANQUIL Healing Center

Health History Form

Name: _____ DOB: _____ Date: _____

Drug Allergies:_____

_____

_____

_____

Current Medications

Please itemize all medications you are currently using or have used recently .
Please be sure to include all over the counter medications and hormones.

Drug Name	Reason for Use	Dose	How Long?	Prescriber

Current Supplements

Please list all vitamins. Minerals herbs, and other natural products you are currently using or have used recently

Product Name	Reason for Use	Dose	How Long?	Prescriber

TRANQUIL Healing Center

Health History Form

Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____ Wt. 1 year ago: _____ Max Wt. _____

What health concerns would you like Dr. Terra to help you with? : _____

_____

_____

_____

_____

Rate your commitment: level to your health.

Low 1 2 3 4 5 6 7 8 9 10 High

How long do you think it will take you to get well? Why? _____

_____

Early Health History

Did your mother have problems during her pregnancy with you? Yes _____ No _____

If yes, please describe: _____

_____

Were you: ☐ breast fed? _____ mo / yr ☐ bottle fed? _____ mo / yr

Please check if you have had any of the following childhood illnesses:

☐ frequent ear infections ☐ colic ☐ eczema ☐ recurrent colds

☐ bronchitis ☐ pneumonia ☐ meningitis ☐ other

Were you on frequent or prolonged antibiotic therapy? ☐ Yes ☐ No

Immunizations

☐ I have chosen not to be vaccinated

Did you receive standard immunizations? ☐ Yes ☐ No

Please provide a copy of your immunization record.

Did you experience any adverse reactions from immunizations? ☐ Yes ☐ No

If yes, what was the reaction? _____

Do you receive a regular influenza vaccination? ☐ Yes ☐ No

Do you have any additional immunizations? (if yes, please list) ☐ Yes ☐ No

_____

_____

Name: _____ DOB: _____ Date: _____

Health Procedures:

Please check if you have had the following health maintenance procedures within the last 5 years, and please provide dates.

- ☐ Full Physical Exam date: _____ Findings? _____
- ☐ Dental Exam date: _____ Findings? _____
- ☐ Cholesterol Check date: _____ Findings? _____
- ☐ CBC, Chemistry, thyroid date: _____ Findings? _____
- ☐ Colonoscopy: date: _____ Findings? _____
- ☐ Eye Exam: date: _____ Findings? _____
- ☐ EKG: date: _____ Findings? _____
- ☐ DEXA (bone 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TRANQUIL Healing Center

Health History Form

Name: _____ DOB: _____ Date: _____

Review of Systems

Please Circle all that apply.

Y = present condition **N** = never had the condition **P** = past problem **F** = Family member

General

Dizziness	Y N P F	Night Sweats	Y N P F	Fatigue	Y N P F		

Head:

Headaches	Y N P F	Migraines	Y N P F	Jaw/ TMJ	Y N P F	Vision	Y N P F
Hearing	Y N P F	Smelling	Y N P F	Tasting	Y N P F	Dental	Y N P F

Skin

Rashes	Y N P F	Eczema, hives	Y N P F	Color Changes	Y N P F	Moles	Y N P F
Skin Cancers	Y N P F						

Musculoskeletal

Joint pain	Y N P F	Muscle spasm	Y N P F	Weakness	Y N P F	Breaks/ Sprains	Y N P F

Neurologic

Fainting	Y N P F	Numb/ tingling	Y N P F	Weak muscles	Y N P F	Seizures	Y N P F
Paralysis	Y N P F	Loss of memory	Y N P F	Neuropathy	Y N P F		

Emotional

Mood swings	Y N P F	Nervousness	Y N P F	Tension/ stress	Y N P F	Anxiety	Y N P F
Depression	Y N P F						

Endocrine

Excessive Thirst	Y N P F	Cold intolerance	Y N P F	Thyroid issues	Y N P F	Diabetes	Y N P F
Excessive hunger	Y N P F	Heat intolerance	Y N P F				

Cardiovascular / Respiratory

Cough	Y N P F	Short of Breath	Y N P F	Asthma	Y N P F	Chest Pain	Y N P F
Abdominal pain	Y N P F	Blood clots	Y N P F	Heart disease	Y N P F	Low / high BP	Y N P F

Gastrointestinal

Diarrhea	Y N P F	Constipation	Y N P F	Abdominal pain	Y N P F	Blood in stool	Y N P F
Nausea /Vomiting	Y N P F	BM per day	_____				

Urinary

Incontinence	Y N P F	Infections	Y N P F	Painful urination	Y N P F	Stones	Y N P F

Males

Hernias	Y N P F	Testicular mass	Y N P F	Sexual difficulty	Y N P	Trauma / injury	Y N P

Female

Age of 1st Menses _____ Age last Menses _____ Length of Cycle _____ Duration Bleeding _____

Number of Pregnancies _____ Number of live Births _____ Number of Miscarriages _____ Number of Abortions _____

Birth Control Y N P If yes, what type? _____ How long? _____

TRANQUIL Healing Center

Health History Form

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? _____ How many years? _____

Smoker in your household? ☐ yes ☐ no

Do you use recreational drugs? ☐ yes ☐ no If yes, please list: _____

Former drug use? ☐ yes ☐ no If yes, please list: _____

Alcohol Use: ☐ none Type: _____ Amount/ frequency: _____

Job: _____ Satisfaction: ☐ Excellent ☐Good ☐ Fair ☐ Poor

Vacation Frequency: # per year _____ Travel frequency: # per year _____

Do you have occupational health risks? ☐ yes ☐ no

If yes, please list: _____

Sleep Schedule: Time to bed _____ Time to wake _____ Naps _____

Sleep Quality: ☐ well rested ☐tired when waking ☐ awake during night

☐ sleep in total dark ☐sleep with some light in 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: _____ Date: _____

Environmental Sensitivities/ exposures

Do you have adverse reactions to any of the following:

Odors:	☐ yes	☐ no	reaction: _____
Smoke:	☐ yes	☐ no	reaction: _____
Soap:	☐ yes	☐ no	reaction: _____
Fumes:	☐ yes	☐ no	reaction: _____
Perfumes:	☐ yes	☐ no	reaction: _____
Dust:	☐ yes	☐ no	reaction: _____
Grasses:	☐ yes	☐ no	reaction: _____
Pollen:	☐ yes	☐ no	reaction: _____
Animals:	☐ yes	☐ no	reaction: _____
Mold:	☐ yes	☐ no	reaction: _____

Have you been exposed to chemicals, now or in the past? ☐ yes ☐ no

If yes, which ones?: _____

Have you been exposed to heavy metals, now or in the past? ☐ yes ☐ no

If yes, which ones?: _____

Do you have multiple electronic devices in your bedroom? ☐ yes ☐ no

Do you live near power lines or a power substation? ☐ yes ☐ no

Additional Information

Please provide any additional information that you would like the doctor to know :

_____

_____

_____

By signing below I confirm that the information provided on this form is truthful to the best of my knowledge. I give Tranquil Healing Center, PS and Dr. Terra Sowinski permission to use this information to assist in providing healthcare to me only (or the patient if guardian is signing) and securing payment from my insurance company if requested.

_____ _____

Signature Date

_____

Printed Name