Advocate Integrated Medicine
215 East Watauga Ave, Suite 100 Johnson City, TN 37601
Phone 423-388-3643 Fax 423-388-3561

Comprehensive Health History Form

Patient Information

Patient Name: _____
(last) *(first)* *(middle initial)*

Address: _____

City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

SS#:_____ DOB: _____ Age: _____

Status: □ Single □ Married □Widowed □Divorced □Separated □Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

How Did You Hear About Us?

□ Referral: _____ □ Direct Mail
□ Internet □ Magazine
□ TV □ Other: _____

What specific condition prompted you to choose us for your healthcare needs?

_____

_____

Accident Information

Do you currently have an active accident claim? □ Yes □ No Date _____

Type of Accident: □ Auto □ Work □ Home □ Other _____

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Work Comp □ Other _____

Attorney Name: (*if applicable)*

_____

Primary Care

Primary Care Physician's Name _____

Clinic Name _____ Phone Number _____

I allow my health progression to be shared with my primary care physician:

□ Yes □ No

Do you have current X-rays at another office or clinic?

□ Yes □ No

Insurance Information

Who is responsible for this account? □ Self □ Other: _____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient covered by additional Insurance? □ Yes □ No

Insurance Company: _____

Policy # _____ Group # _____

Subscribers Name: _____

DOB: _____ SS#: _____

Relationship to Patient: _____

Assignment of benefits and Release

I understand and agree that (regardless of whatever health or medical benefits I have), **I am ultimately responsible to pay AIM, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided**.

I hereby authorize payment of any health insurance or medical plan benefits directly to **AIM,** for medical services rendered and for any supplies, tests or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to **AIM,** all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

This assignment includes, but not limited to, a designation that **AIM,** can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to **AIM**, as a result of services rendered by **AIM,** and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer.

I acknowledge receipt of HIPAA and patient Rights.

This assignment and designation remain in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____
DATE

Medications

Current Medication **Dosage/How Long** **For What Condition?**

_____

_____

_____

Please List Previous Medications (Last 10 Years)

Medication **Dosage/How Long** **For What Condition?**

_____

_____

_____

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No Describe:

_____

_____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin? □ Yes □ No

Tylenol? □ Yes □ No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)? □ Yes □ No

Frequent Antibiotics (> 3 times a year) □ Yes □ No

Long Term Antibiotics □ Yes □ No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers) □ Yes □ No

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc)*
□ Yes □ No If yes, where located _____

Current Herbal Medications

Medication **Dosage/How Long** **For What Condition?**

_____

_____

_____

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** □ **Light Activity** □ **Moderate Activity**

□ **Heavy Activity** □ **Vigorous Activity**

Please check all that apply:

□ Tobacco – Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? Yes No

□ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have previously used recreational drugs? Yes No

If yes, what types/method (IV, inhaled, smoked, etc) _____

_____

Current Condition

If you had a magic wand and could erase 3 of your health problems, what would they be?

1. _____
2. _____
3. _____

What do you hope to achieve in your visit with us?

_____

_____

When did the condition(s) begin?

_____

_____

Has it occurred before? □ Yes □ No When? _____
Is the condition getting worse? □ Yes □ No □ Unknown
Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause
□ Other _____
Rate the severity of your pain from 1 (least) to 10 (severe) _____
How often do you have this pain? _____
Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation
What treatment have you received for your condition?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services
□ None □ Other _____
Please list Current and Ongoing Problems in Order of Severity:

Problem _____
□ Mild □ Moderate □ Severe

Treatment/Approach _____

Success: □ Excellent □ Good □ Fair

Problem _____
□ Mild □ Moderate □ Severe

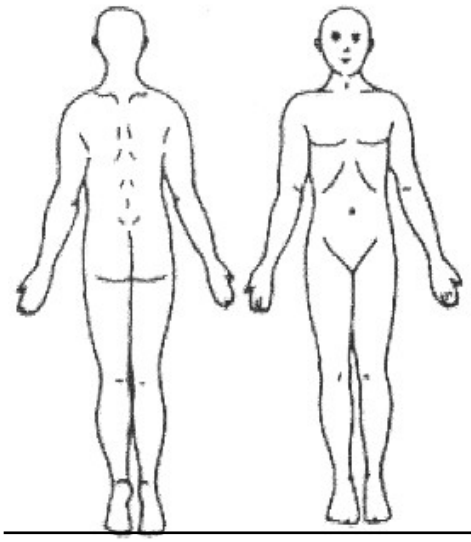
Treatment/Approach _____

Success: □ Excellent □ Good □ Fair

Problem _____
□ Mild □ Moderate □ Severe

Treatment/Approach _____

Success: □ Excellent □ Good □ Fair



Label on the Diagram the CURRENT Areas of Discomfort:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins & Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Health History Please *check* all that apply (past or present)

___Alzheimer's
___ Bleeding Disorders
___ Auto Immune Disorder
___ Chronic Fatigue Syndrome
___ Glaucoma
___ Heart Disease
___ Herniated Disk
___ Hormone Replacement
___ Migraine Headaches
___ Polio
___ Psychiatric Care
___ Sleep Apnea
___ Tumors, Growths
___ Anemia
___ Blood Clot
___ Cancer
___ CVA (Stroke)
___ Gout
___ Heart Failure
___ High Blood Pressure
___ Kidney Stones
___ Osteoporosis
___ Pregnancy
___ Scoliosis
___ Stroke
___ Other: _____
___ Arthritis
___ Blood Transfusion
___ Cerebral Palsy
___ Diabetes
___ Headaches
___ Hepatitis
___ Liver Disease
___ Pacemaker
___ Prostate Problems
___ Seizure Disorder
___ Swelling Feet
___ Asthma
___ Cataracts
___ Vertigo
___ Fibromyalgia
___ Heart Attack
___ Hernia
___ High Cholesterol
___ Lung Disease
___ Pinched Nerve
___ Prosthesis
___ Sinusitis
___ Thyroid Problems

Family Health History

Check all family members that apply	Mother	Father	Brother (s)	Sister (s)
Age (if still alive)				
Age at Death (if deceased)				
Cancers :				
Heart Disease				
Diabetes				
Stroke				
Auto Inmune Disease:				
Inflammatory Bowel Disease				
Multiple Sclerosis				

Daily Activities

Effects of Current Condition on Daily Performance

Please mark for each CURRENT Condition:

1=No Effect
2=Slightly Limited
3=Limited
4=Mostly Limited
5=Unable to Perform

Bending	1 2 3 4 5
Carrying	1 2 3 4 5
Climbing	1 2 3 4 5
Concentrating	1 2 3 4 5
Computer Work	1 2 3 4 5
Dancing	1 2 3 4 5
Doing Chores	1 2 3 4 5
Dressing	1 2 3 4 5
Driving	1 2 3 4 5
Gardening	1 2 3 4 5
Jumping	1 2 3 4 5
Lifting	1 2 3 4 5
Playing Sports	1 2 3 4 5
Pushing	1 2 3 4 5
Reading	1 2 3 4 5
Rolling Over	1 2 3 4 5
Sexual Activity	1 2 3 4 5
Shoveling	1 2 3 4 5
Sitting	1 2 3 4 5
Sitting to Standing	1 2 3 4 5
Sleeping	1 2 3 4 5
Standing	1 2 3 4 5
Walking	1 2 3 4 5
Watching	1 2 3 4 5
Working	1 2 3 4 5

Medical History

Please check all that apply / Indicate When and any Comments/Results

Injuries (What and When)

___ Back Injury_____
___ Head Injury_____
___ Neck Injury_____
___ Soft Tissue_____
___ Broken Bones/Fractures_____
___ Industrial_____
___ Severe Fall_____
___Other_____

Surgeries/Hospitalizations (what and when)

_____
_____
_____

Review of Systems

Indicated which of the below you have experienced in the **last 1-2 months.**
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Ears/Nose

Decreased Hearing	1 2 3 4 5
Headaches	1 2 3 4 5
Nose Bleeds	1 2 3 4 5
Ringing in Ears	1 2 3 4 5
Snoring	1 2 3 4 5
TMJ	1 2 3 4 5

Eyes/Vision

Blindness	1 2 3 4 5
Blurred/Double Vision	1 2 3 4 5
Cataracts	1 2 3 4 5
Field Cuts	1 2 3 4 5
Photophobia	1 2 3 4 5
Tearing	1 2 3 4 5
Wear Glasses/Contacts	1 2 3 4 5

Skin

Dryness	1 2 3 4 5
Itching	1 2 3 4 5
Lumps	1 2 3 4 5
Skin Color Changes	1 2 3 4 5
Rashes	1 2 3 4 5
Skin Lesions	1 2 3 4 5
Varicosities	1 2 3 4 5

Gastrointestinal

Hernia	1 2 3 4 5
Abdominal Pain/Cramps	1 2 3 4 5

Notes:_____
_____

Cardiovascular

Angina	1 2 3 4 5
Leg pain/ache	1 2 3 4 5
Difficulty Breathing Lying	1 2 3 4 5
Heart Problems	1 2 3 4 5
High Blood Press	1 2 3 4 5
Low Blood Pressure	1 2 3 4 5
Palpitations	1 2 3 4 5
Shortness of Breath	
Swelling of Legs	1 2 3 4 5
Ulcers	1 2 3 4 5
Varicose Veins	1 2 3 4 5

Muscular/Skeletal

Ankle/Foot Pain	1 2 3 4 5
Arthritis	1 2 3 4 5
Balance Problems	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Weakness in Arms/Legs	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5

Hematologic

Anemia	1 2 3 4 5
Ease of Bleeding	1 2 3 4 5
Blood Clotting	1 2 3 4 5
Blood Transfusion	1 2 3 4 5
Bruise Easily	1 2 3 4 5

Reproductive

STI's	1 2 3 4 5

Neurological

Dizziness	1 2 3 4 5
Facial/Limb Weakness	1 2 3 4 5
Fainting/Headaches	1 2 3 4 5
Numbness	1 2 3 4 5
Unsteadiness of Gait	1 2 3 4 5

Mental/Emotional

Clumsy	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Memory Loss	1 2 3 4 5
Mood Swings/Irritability	1 2 3 4 5
Poor Concentration	1 2 3 4 5
Restless Leg Syndrome	1 2 3 4 5

Urinary

Incontinence	1 2 3 4 5
Kidney Stone	1 2 3 4 5
Urgency	1 2 3 4 5

Endocrine

Abnormal Urination	1 2 3 4 5
Decreased Endurance	1 2 3 4 5
Diabetes	1 2 3 4 5
Excessive Hunger	1 2 3 4 5
Excessive Thirst	1 2 3 4 5
Fatigue/Drowsiness	1 2 3 4 5
Goiter	1 2 3 4 5
Hair Loss/Hair Growth	1 2 3 4 5
Hot Flashes/Night Sweats	1 2 3 4 5
Hypo/Hyper Thyroid	1 2 3 4 5