Coastal Integrative Medicine

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www.coastalintegrativemedicine.com

Date: _____

First Name: _____ Last Name: _____ Date of Birth: _____

Street Address: _____ City: _____ ST: _____ Zip: _____

Social Security Number: _____ Phone Number: _____ Cell Phone: _____

Work: _____ Email: _____ Marital Status: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Race: American Indian, Asian, African American, Other Pacific Islander, Caucasian Primary Language Spoken: _____

PHARMACY: _____ Pharmacy Phone Number: _____

Person to contact in case of EMERGENCY: _____ Phone Number: _____

Referred by: _____ Insurance: _____ Is this visit due to an accident? Y/N

Reason for today's visit: _____

MEDICATION LIST

Medication	Dosage(MG)	Frequency	Time of Day

DRUG ALLERGIES: _____ REACTION: _____

PAST MEDICAL HISTORY

❑ Hypertension ❑ Chest Pain ❑ Heart Attack ❑ Angina ❑Anxiety ❑ Back Pain

❑ Neck Pain ❑ Leg Pain ❑ PVD ❑ Migraines ❑Depression ❑ Mental Issues

❑ Diabetes ❑ Stroke (TIA) ❑ Coronary Artery Disease ❑ High Cholesterol ❑ Gallstones

❑ Kidney Disease (Please Specify) _____ ❑ Liver Disease (Please Specify)_____

❑ Lung Disease (Please Specify) _____ ❑ Thyroid Disease (Please Specify) _____

❑ Cancer (Please Specify) _____ ❑ Joint Pain/Arthritis (Please Specify) _____

❑ Heart (Please Specify) _____ ❑ Other: _____

Last Colonoscopy: _____ Last PSA: _____

Women Only: Last Pap Smear: _____ Last Mammo: _____ Last Bone Density: _____

PAST HOSPITAL/SURGICAL HISTORY

Type of Hospitalization/Surgery: Date: Location:

_____

_____

_____

_____

SOCIAL HISTORY

Number of Children: _____ Occupation: _____

Current Smoker: Yes / No # of packs per day: _____ For how many years: _____

Former Smoker: Yes / No # of packs per day: _____ For how many years: _____

Alcohol use: Yes / No If yes, How much per day/week/Month _____

Caffeine use: Yes / No If yes, How many per day: _____

Nutrition: Low Fat Diet / Diabetic Diet / Vegetarian / Low Carb / Regular

Exercise: Yes / No Illicit Drugs use: Yes / No If yes, what kind: _____

Seat belt user: Yes / No Do you feel safe at home? Yes / No If no, please explain: _____

FAMILY HISTORY

	Age (If Living)	Age at Death	Cause of Death / Illness History
Mother:	_____	_____	_____
Father:	_____	_____	_____
Siblings:	_____	_____	_____

HIPPA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be directly and indirectly involved in my treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been given the right to review the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bounded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relaying on this consent.

Patient Name(printed): _____ Patient Name(signed): _____

Please list all relatives and friends in which we can discuss your results with:

1. _____ 2. _____