INTOUCH WELLNESS CENTER

2302 W Greenway Rd. – Phoenix, AZ – 85023 – (602)548-1998 – www.intouchwellnesscenter.com

Name_____ Nickname_____ How did you hear about us?_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone _____

Home Email_____ Date of Birth_____ Age_____

Gender ❑ Male ❑ Female ❑ Unspecified

Emergency Contact:_____ Contact Phone#_____

Marital Status ❑ Single ❑ Married ❑ Other Children ❑ YES ❑ NO How Many_____

Employment Status ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____ Employer_____ Employer Phone_____

Do you have insurance?❑ Yes ❑ No Insurance Type_____

Primary insured?❑ Yes ❑ No If no, primary insured name and relationship to self: _____Their DOB_____

Family Physician_____ Phone Number_____

List any known allergies you have had to any medications, foods or environment:

1) _____ 2) _____ 3) _____ 4) _____

Do you suffer from seasonal allergies? ❑ Yes ❑ No If Yes, have you had allergy testing before? ❑ Yes ❑ No

Do you suffer from food sensitivity? ❑ Yes ❑ No If Yes, have you had food sensitivity testing before? ❑ Yes ❑ No

Rx Medication/Over The Counter

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Health History: Please mark any condition you currently have issues with

GENERAL
□Night Sweats
□Weight Loss
□Fatigue
□Fever

MSK
□Joint pain
□Stiffness
□Muscle Pain
□Swollen Joints

PSYCHIATRIC
□Anxiety
□Depression

ENT
□Difficulty Hearing
□Ear Ringing
□Vertigo

GU
□Erectile Dysfunction
□ Leaky Bladder
□Blood in Urine
□Frequent Urination
□ Painful Urination
□ Decreased Libido

HEMATOLOGY
□Easy Bruising
□ Easy Bleeding

ENDOCRINE
□Hair Loss
□Weight Gain

RESPIRATORY
□Coughing
□Asthma
□Difficulty Breathing

CARDIOVASCULAR
□Heart Murmur
□Chest Pain
□Palpitations
□Heart Attack
□Fainting
□Swollen Ankles

FEMALES
□Abnormal Mammo
□Abnormal Pap
□Vaginal Dryness
Pregnant Yes or No

GI
□Heartburn
□Nausea
□Constipation
□Diarrhea

EYES
□Glasses
□Eye Pain
□Double Vision

SKIN
□Rash
□Itching
□Lesions

NEUROLOGICAL
□Strength Loss
□Numbness
□ Memory Loss
□Headaches
Frequency_____

FAMILY (F) OR SELF (S) HISTORY

(F)(S) Alcoholism
(F)(S) Anemia
(F)(S) Asthma
(F)(S) Cancer/Tumor
(F)(S) Diabetes
(F)(S) Drug Abuse
(F)(S) Depression
(F)(S) Epilepsy/Seizures
(F)(S) High Blood Pressure
(F)(S) Kidney Disease
(F)(S) Liver Disease
(F)(S) Hepatitis
(F)(S) Lung Disease
(F)(S) Rheumatic Arthritis
(F)(S) Osteoarthritis
(F)(S) Osteoporosis
(F)(S) Stroke

(F)(S) Suicide Attempt
(F)(S) Thyroid Disease
(F)(S) Heart Disease
(F)(S) Ulcers
(F)(S) HIV
(F)(S) Immune Disease
List _____
(F)(S) High Cholesterol
Notes:_____

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PLEASE FILL OUT COMPLETELY

1st Chief Complaint: _____ When did it start? _____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint :_____ When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____ When did it start? _____ Gradual / Sudden

Circle the current pain level of your complaint:

1 2 3 4 5 6 7 8 9 10

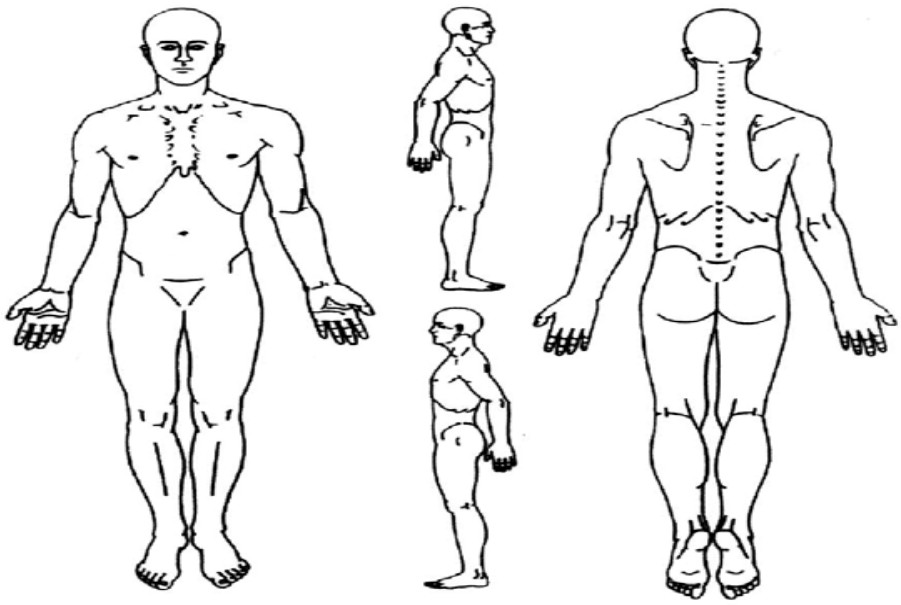
Mild Severe

Circle the percentage of the day you experience the complaint:

10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show where you are experiencing ALL of your current complaints



A: Ache

B: Burning

C: Cramping

D: Dull Pain

F: Stiffness

N: Numbness

R: Throbbing

S: Soreness

T: Tingling

X: Sharp Pain

Print Name:_____

Patient Signature:_____ **Date:**_____