TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE AT INTEGRATED MEDICINE OF OHIO

2780 S. Arlington Rd, Suite 202
Akron, Ohio 44312
330.644.5488

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A one-on-one consultation will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to Determine the precise cause of you problem is given by the doctors.

STEP FOUR:
The doctors will advise you if x-rays are needed.

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of your treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:
If you are accepted as a patient, care will begin. Additional explanation will be given on the different types of treatment that are available in the office.

STEP SEVEN:
An estimate of the future care that is needed will be given based on your decision, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

PATIENT INITIALS_____

Office Use ONLY	#
Demographics	
Day 0	
Day 1	
Letter	
Call Slip	

Confidential Patient Health Record

Date: _____

Name_____ Date of Birth_____Age _____

Address_____City_____State_____Zip_____

SS#_____-_____-_____ Male / Female Email Address_____@ _____

Home #_____Cell #_____Cell Phone Carrier _____

Occupation_____Employer_____Work # _____

Employer's Address_____

City_____State_____Zip Code_____

Marital Status_____Spouse's Name_____

Spouse's Occupation_____Spouse's DOB_____

How Many Children Do You Have?_____Children's Ages_____

Emergency Contact Name_____Phone #_____

Do You Drink Alcoholic Beverages? ☐Yes ☐No How Often?/How Much?_____

Do You Smoke? ☐Yes ☐No How Often?/How Much?_____

Do You Exercise? ☐Yes ☐No How Often?/How Much?_____

Do You Have Any Allergies? (Specify)_____

Are You Pregnant? ☐Yes ☐No ☐Not Sure Date of Last Period?_____

Have You Ever Received Chiropractic Care? ☐Yes ☐No Last Visit Date?_____

Did They Take X-Rays? ☐Yes ☐No ******Referred To This Office By**_____

What Medications Are You Currently Taking? _____

_____

What Surgeries Have You Had?_____

_____

List Any Recent Accidents or Falls_____

CHIEF COMPLAINT

What Is Your Primary Complaint? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

SECONDARY COMPLAINT

What Is Your Secondary Complaint? _____

How Long Have You Been Experiencing This Problem? _____

On A Scale of 1 to 10, How Severe Is It At It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

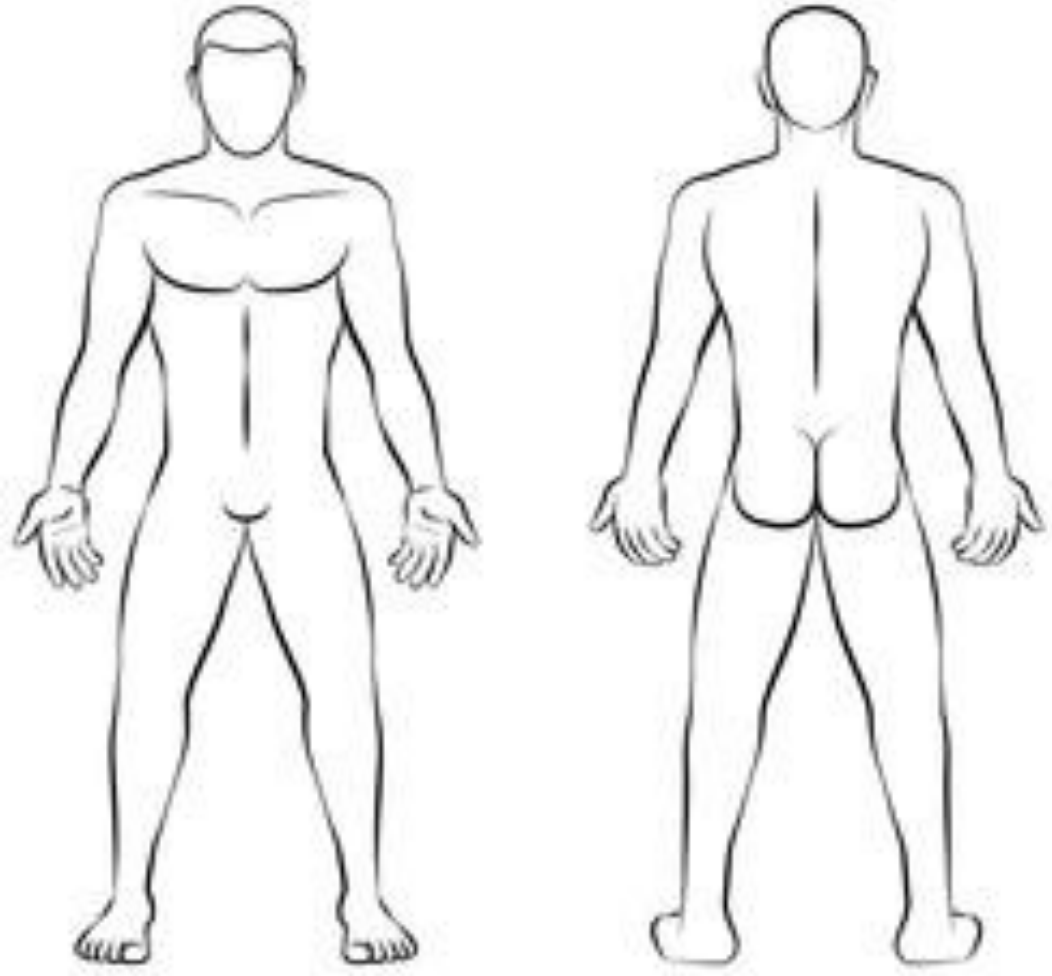
What Makes it Feel Better? _____ Feel Worse? _____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

On the diagram below, label ALL areas you are experiencing symptoms
using the appropriate letter from the Key box below.

A = Aching **C** = Cramping **R** = Throbbing Pain **N** = Numbness **O** = Other
B = Burning **D** = Dull **S** = Stiffness **T** = Tingling



CONFIDENTIAL HEALTH REPORT

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C GENERAL
___ ___ ___Allergy
___ ___ ___ Chills
___ ___ ___ Convulsions
___ ___ ___Dizziness
___ ___ ___Fainting
___ ___ ___Fatigue
___ ___ ___ Fever
___ ___ ___ Headache
___ ___ ___ Loss of sleep
___ ___ ___ Loss of weight
___ ___ ___ Nervousness/depression
___ ___ ___ Neuralgia
___ ___ ___ Numbness
___ ___ ___ Sweats
___ ___ ___Tremors

O F C
MUSCLE & JOINT
___ ___ ___ Arthritis
___ ___ ___ Bursitis
___ ___ ___ Foot trouble
___ ___ ___ Hernia
___ ___ ___ Low back pain
___ ___ ___ Lumbago
___ ___ ___ Neck pain or stiffness
___ ___ ___ Pain between
shoulders Pain or numbness in:
___ ___ ___ Shoulders
___ ___ ___ Arms
___ ___ ___ Elbows
___ ___ ___ Hands
___ ___ ___ Hips
___ ___ ___ Legs
___ ___ ___ Knees
___ ___ ___ Feet
___ ___ ___ Painful tail bone
___ ___ ___Poor posture
___ ___ ___ Sciatica
___ ___ ___ Spinal Curvature
___ ___ ___Swollen joints

O F C
GASTRO-INTESTINAL
___ ___ ___ Belching or gas
___ ___ ___ Colitis
___ ___ ___ Colon trouble
___ ___ ___ Constipation
___ ___ ___ Diarrhea
___ ___ ___ Difficult digestion
___ ___ ___ Distension of abdomen
___ ___ ___ Excessive hunger
___ ___ ___Gall bladder trouble
___ ___ ___ Hemorrhoids
___ ___ ___ Intestinal worms
___ ___ ___ Jaundice
___ ___ ___ Liver trouble
___ ___ ___Nausea
___ ___ ___ Pain over stomach
___ ___ ___Poor appetite
___ ___ ___Vomiting
___ ___ ___ Vomiting of blood

O F C
EYES, EARS, NOSE & THROAT
___ ___ ___ Asthma
___ ___ ___ Colds
___ ___ ___ Crossed eyes
___ ___ ___ Deafness
___ ___ ___ Dental Decay
___ ___ ___Earache
___ ___ ___ Ear discharge
___ ___ ___ Ear noises
___ ___ ___ Enlarged glands
___ ___ ___Enlarged thyroid
___ ___ ___ Eye pain
___ ___ ___Failing vision
___ ___ ___ Far sightedness
___ ___ ___Gum trouble
___ ___ ___Hay fever
___ ___ ___ Hoarseness
___ ___ ___ Nasal obstruction
___ ___ ___ Near sightedness
___ ___ ___Nosebleeds
___ ___ ___ Sinus infection
___ ___ ___Sore throat
___ ___ ___ Tonsillitis

O F C
CARDIO-VASCULAR
___ ___ ___ Hardening of arteries
___ ___ ___ High blood pressure
___ ___ ___ Low blood pressure
___ ___ ___Pain over heart
___ ___ ___Poor circulation
___ ___ ___Rapid heart beat
___ ___ ___ Slow heart beat
___ ___ ___ Swelling of ankles

O F C
RESPIRATORY
___ ___ ___ Chest pain
___ ___ ___ Chronic cough
___ ___ ___ Difficult breathing
___ ___ ___Spitting up blood
___ ___ ___ Spitting up phlegm
___ ___ ___Wheezing

O F C
SKIN
___ ___ ___ Boils
___ ___ ___ Bruise easily
___ ___ ___Dryness
___ ___ ___Hives or allergy
___ ___ ___ Itching
___ ___ ___ Skin eruptions (rash)
___ ___ ___ Varicose veins

O F C
GENITO-URINARY
___ ___ ___Bed-wetting
___ ___ ___ Blood in urine
___ ___ ___ Frequent urination
___ ___ ___Inability to control kidneys
___ ___ ___ Kidney infection or stones
___ ___ ___ Painful urination
___ ___ ___ Prostate trouble
___ ___ ___Pus in urine

O F C
FOR WOMEN ONLY
___ ___ ___Cramps or backache
___ ___ ___Excessive menstrual flow
___ ___ ___ Hot flashes
___ ___ ___Irregular cycle
___ ___ ___Menopausal symptoms
___ ___ ___ Painful menstruation
___ ___ ___Vaginal discharge

Yes No Are you or could you possibly be pregnant?

HABITS	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□

****What are your Hobbies?** _____

_____

FAMILY HISTORY

Please put an **x** to indicate if any member of your family has had these diseases.
(Family history includes your parents, grandparents, siblings, and your children.)

Condition	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( )	Age( )	SISTER(S) Age( )	Age( )	CHILDREN Age( )	Age( )	Age( )
Blindness										
Cataract										
Diabetes										
Glaucoma										
High Blood Pressure										
Cancer										
Heart Disease										
Thyroid Disease										
Arthritis										
Stroke										
Macular Degeneration										
Other Inherited Disease										
Blood Clots (Deep Vein Thrombosis)										
Blood Clots (Pulmonary Embolisms)										
Blood Clots(Stroke)										

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable and any discounts will be forfeited.

I hereby authorize the Providers to treat my condition as he/she deems appropriate. It is understood and agreed the amount paid to the Doctor, for x-rays is for the examination only and the X-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature_____
Date_____

Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor of course will not provide specific healthcare, if he/she is aware that such care may be contraindicated. The responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the physician.
I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing:

Patient Signature:_____ **Date:** _____

Consent to Treat a Minor_____
Date_____

Guardian or Spouse's Signature Authorizing Care_____
Date_____