

**Midtown Integrative Health & Wellness**

**515 Madison Avenue, 6<sup>th</sup> Floor**

**New York, NY 10022**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
Last First mm/dd/yyyy

**Address:** \_\_\_\_\_  
Street City, State Zip Code

**Gender** (please circle one): Male Female **Marital Status:** Single Married Divorced Widowed

**Home Phone:** \_\_\_\_\_  check if cellular phone **Work:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

*We confirm all patient appointments via email.*

Check here if you would like to be added to our health newsletter mailing lists.

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**How did you hear about us? Did someone refer you?** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Employer's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Employer's Address:** \_\_\_\_\_  
Street City, State Zip Code

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Pharmacy & Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Interest in health & wellness services:**

Acupuncture	Yes	No
Bio-feedback Counseling	Yes	No
Cardiology	Yes	No
Chiropractic Care	Yes	No
Integrative Medicine	Yes	No
Internal Medicine	Yes	No
Massage Therapy	Yes	No
Non-surgical Orthopedics	Yes	No
Nutrition	Yes	No
Physical Therapy	Yes	No
Stress Management	Yes	No
Weight-Loss	Yes	No

*I consent to treatment that is received in this office. I understand that my personal information is available to all medical providers at this location. I have received a copy of the office's notice of privacy practices and authorize the release of any medical or other information necessary to process a claim with my insurance. I request payment of insurance benefits either to myself or the party accepting assignment. I understand that I am responsible for any copay, deductible or expenses incurred that are not covered under my medical insurance.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What are your chief health concern(s)? \_\_\_\_\_

How did your problem begin? \_\_\_\_\_

Have you had this problem before? Were any diagnostic imaging (x-rays, MRIs, etc) performed?

Have you seen other doctors for this condition?  Yes  No

If so, please list the type of treatment received and the contact information for the other doctor(s):

\_\_\_\_\_  
\_\_\_\_\_

Please list any relevant medical history, including surgeries (type and year), injuries, hospitalizations, illnesses:

\_\_\_\_\_  
\_\_\_\_\_

Has anyone in your family had a similar complaint? \_\_\_\_\_

Are you currently on any medications and supplements?

Name/Type	Dosage	Frequency	Date Started	Date Stopped

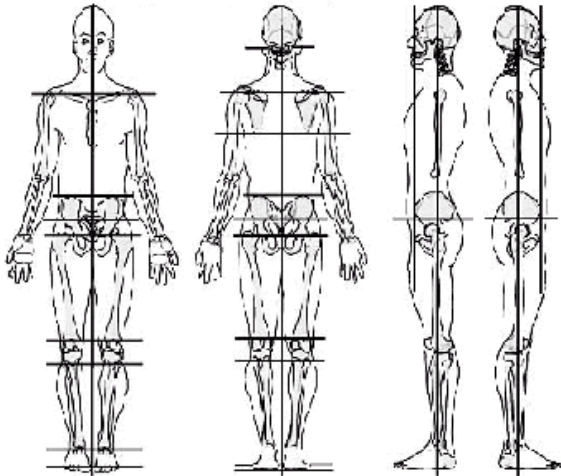
Please list any allergies: \_\_\_\_\_

Current height: \_\_\_\_\_ Date of last measurement: \_\_\_\_\_

Current weight: \_\_\_\_\_ Date of last measurement: \_\_\_\_\_

How much did you weigh in...high school? \_\_\_\_\_ 20s? \_\_\_\_\_ 30s? \_\_\_\_\_ 40s? \_\_\_\_\_ 50s? \_\_\_\_\_ 60s? \_\_\_\_\_

Circle the area(s) on the model if experiencing pain.



What makes the problem better? (select all that apply):

<input type="checkbox"/>	Cold	<input type="checkbox"/>	Inactivity	<input type="checkbox"/>	Movement	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Walking
<input type="checkbox"/>	Heat	<input type="checkbox"/>	Lying Down	<input type="checkbox"/>	Nothing	<input type="checkbox"/>	Standing	<input type="checkbox"/>	Other

What makes the problem worse? (select all that apply):

<input type="checkbox"/>	Cold	<input type="checkbox"/>	Inactivity	<input type="checkbox"/>	Movement	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	Walking
<input type="checkbox"/>	Heat	<input type="checkbox"/>	Lying Down	<input type="checkbox"/>	Nothing	<input type="checkbox"/>	Standing	<input type="checkbox"/>	Other

How would you describe the pain? (select all that apply):

<input type="checkbox"/>	Aches	<input type="checkbox"/>	Gripping/Constricting	<input type="checkbox"/>	Sharp/Stabbing	<input type="checkbox"/>	Tingling
<input type="checkbox"/>	Burning	<input type="checkbox"/>	Itching	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Dull	<input type="checkbox"/>	Sharp/Dull	<input type="checkbox"/>	Throbbing/Gnawing	<input type="checkbox"/>	Other

How bad is your pain or problem? (please circle; 0 = no pain, 10 = unbearable) 0 1 2 3 4 5 6 7 8 9 10

How is your lifestyle being affected due to the pain? \_\_\_\_\_

What time is the pain most severe? \_\_\_\_\_ Least severe? \_\_\_\_\_

Preventative tests history:

	Month/Year of Last Test	Test Results
Blood Sugar		
Bone Density		
Cholesterol		
Colonoscopy		
EKG		
Mammogram		
Prostrate Screening		
Stress Tests		

**Family medical history:**

	Yes	No	
			If No, provide age of death:
Mother Living?			
Father Living?			
			Write relationship of relative(s) with the below conditions:
Allergies			
Arthritis			
Asthma			
Breast Cancer			
Colon Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Prostate Cancer			
Seizures			
Skin Disorders			
Stroke			
Uterine/Ovarian Cancer			
Other Diseases/Conditions			

**Personal medical history (check all that apply):**

**General**

Allergies	Convulsions	Fatigue	Loss of Sleep	Pain in Legs
Bleed/Bruise Easily	Cravings	Headaches	Lyme Disease	Thyroid Disease
Cancer (Specify)	Dental/Gum Issues	Hypo/Hyperglycemia	Numbness	Weight Gain
Chills	Diabetes (Specify)	Iron Deficiency	Pain in Arms	Weight Loss
Chronic Fatigue	Dizziness	Localized Weakness	Pain in Hands	

Additional information: \_\_\_\_\_

**Cardiovascular**

Blood Clotting	High Blood Pressure	Poor Circulation	Shortness of Breadth
Chest Pain/Pressure	Low Blood Pressure	Previous Heart Attack	Slow Heart Beat
Cold Hands/Feet	Pain over Heart	Previous Heart Stroke	Sweat Easily
Fainting	Paralytic Stroke	Rapid Heart Beat	Ankle Swelling
Hardening of Arteries	Phlebitis	Reynaud's Disease	Varicose Veins

Additional information: \_\_\_\_\_

**Gastrointestinal**

Bad Breath	Colon Trouble	Diverticulitis	Hepatitis/Liver Disease	Pain over Stomach
Black Stools	Constipation	Excessive Hunger	Lyme Disease	Poor Appetite
Bloating	Crohn's Disease	Gall Bladder Trouble	Hernia	Stomach Ulcers
Blood in Stool	Diarrhea	Gas	Intestinal Worms	Strong Thirst
Changes in Appetite	Difficult Digestion	Gastro-Esophageal Reflux	Irritable Bowel Syndrome	Vomiting
Colitis	Distention of Abdomen	Hemorrhoids	Nausea	

Additional information: \_\_\_\_\_

**Genito-Urinary**

Bed Wetting	Impotence	Menopausal Symptoms
Blood in Urine	Inability to Control	Painful Menstrual Periods
Cramps or Backache	Infertility Problems	Painful Urination
Excess Flow	Kidney Infection	Pregnant
Frequent Urination	Kidney Stones	Prostate Problems
Herpes	Lumps in Breast	Pus in Urine

Additional information: \_\_\_\_\_

**Head, Eyes, Ears, Nose and Throat**

Blurred Vision	Facial Pain	Peculiar Tastes/Smells
Difficulty Swallowing	Grinding Teeth	Poor Vision
Earaches	Jaw Clicks/Locks	Ringling in Ears
Eye Strain or Pain	Night Blindness	Sinus Problems
Face Flushing	Nose Bleeds	Spots in Front of Eyes

Additional information: \_\_\_\_\_

**Musculoskeletal**

Arthritis	Fibromyalgia	Muscle Pain	Sciatica
Artificial/Joint Problems	Foot/Ankle Pain	Neck Pain	Shoulder Pain
Back Pain	Hand/Wrist Pain	Osteoporosis	Sprains/Strains
Bursitis	Hip Pain	Rheumatoid Arthritis	Stiff Neck
Carpal Tunnel	Knee Pain	Rotator Cuff	Tendonitis

Additional information: \_\_\_\_\_

**Neuropsychological**

	ADD/ADHD		Depression		Poor Concentration
	Alcoholism		Insomnia		Poor Memory
	Anorexia or Bulimia		Lack of Coordination		Psychiatric/Emotional Illness
	Anxiety/Excessive Stress		Numbness		Seizure Disorder
	Bad Temper/Irritable		Panic Attacks		Sexual/Libido Problems
	Concussion		Poor Balance		Vertigo

Additional information: \_\_\_\_\_

**Respiratory**

	Asthma		Difficulty Breathing		Phlegm
	Bronchitis		Emphysema		Pneumonia
	Coughing/Wheezing		Lung/Breathing Problems		Recurrent Sinus Infections
	Cystic Fibrosis		Pain with Deep Inhalation		Tight Sensation in Chest

Additional information: \_\_\_\_\_

**Skin and Hair**

	Acne		Itching		Skin Discoloration
	Change in Skin/Hair		Loss of Hair		Sores on Lips/Tongue
	Dandruff		Psoriasis/Eczema		Warts
	Fungal Infection		Rashes		Weak/Ridged Nails
	Hives		Recent Moles		

Additional information: \_\_\_\_\_

**Social history** (please circle all that apply):

Overall health	Excellent	Good	Fair	Poor
Physical fitness level	Excellent	Good	Fair	Poor
Under a lot of stress	Yes	No		
Difficulty dealing with stress	Yes	No		
Fatigued all the time	Yes	No		
Often sad or blue	Yes	No		
Practice meditation	Yes	No		

**Exercise habits**

Aerobic exercise	None	Routinely Exercise	# Hours/Week _____
	Jog	Walk	Run/Treadmill
	Stretching	Weight Lifting	Yoga
	Other _____		

**Dietary habits**

Try to eat healthy diet	Yes	No	
Special dietary habits	Avoid Red Meat	Gluten Free	Minimize Fat
	Avoid Dairy/Cheese	Minimize Carbs	Vegetarian
Emphasize fruits, grains, veggies	Yes	No	
Commonly eat fast food	Yes	No	
Commonly consume	Candy	Chocolate	Diet Soda
	Chips/Junk Food	Coffee	Regular Soda
Have you met with a dietitian before?	Yes	No	

If yes, for what reason(s)?

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What is one goal you'd like to accomplish by meeting with a registered dietitian?

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What, if any, worries and/or concerns do you have as you start your nutrition counseling?

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**Tobacco use**

Do you smoke	Yes	No	
Do you chew tobacco	Yes	No	
I smoke	Cigarettes	Cigars	Pipes
	#/Per Day _____	# Years _____	
I quit smoking (mo/yr)	_____		

**Alcohol consumption**

Do you drink alcohol of any kind	Yes	No	
I regularly drink	1-2 drinks/day	2+ drinks/day	4+ drinks/day
I typically drink	Beer	Wine	Other _____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_