PATIENT CONFIDENTIAL INFORMATION

Name:____ **Date**:____________________
First Middle Last

Name that you prefer:______________________________________ **Marital**: M S D W **Male**______ **Female**_______

Date of Birth:____________________ **Age**:___________ **Place of Birth**:____

Social Security #:_________________________ **Driver's License #**:___________________ **Occupation**:______________________

Phone:_____________________________________ Lv. Msg? Y N **Cell**:___________________________________ Lv. Msg? Y N

Work:_________________ Lv. Msg? Y N **Fax**:____________________ **Email**:____

Home Address:

____
Street City State Zip

Referred By:____

Current Medical Condition(s)?____

Medication(s) /Supplement(s) you are currently taking? ____
____

Are you Sensitive /Allergic to any Medication, Supplements, or Anesthesia Materials?__________________________
____

Emergency Contact:
Name:____ Relationship:____
Phone :_______________________________ Cell :______________________________ Work :_____________________________

Spousal Information
Name:____ Phone:____
Occupation:_______________________ Employer/Employer Phone :____

For Minors: **List both parents' names, phone numbers, and addresses**
1)____
2)____

Initial________ **CANCELLATION/RESCHEDULE POLICY**: Arizona Integrative Medical Center, P.C. has a 24-hour cancellation/ reschedule policy. If you miss your office or lab appointment or do not contact us to reschedule within 24 hours prior to your scheduled appointment, you will be charged a $50.00 cancellation fee.

Initial________ **FEE/RETURN POLICY:** To help control costs, we ask our patients to pay for visits/procedure/supplements/lab work and any treatment at the time services are rendered. We cannot render services on the assumption that our fees will be paid by an insurance company. Returned checks will incur a $35 fee. Any overdue accounts will be referred to a collection agency. Supplements cannot be returned, for any reason even if unopened, due to safety and sanitation .

Initial________ **ESTIMATES:** Any estimates of anticipated fees, for budgeting purposes or otherwise, are, due to the uncertainties involved, only approximation of potential fees Under no circumstances are such estimates a maximum or minimum fee quotation. Our actual fees will be determined in accordance with this Agreement.

By signing below, I have read and fully understand the Cancellation/Reschedule Policy and Fee Policy, and I understand and agree that I am responsible for the balance on this account and guarantee payment of all charges incurred as a patient of Arizona Integrative Medical Center, P.C. and Paul Stallone, N.M.D. regardless of any insurance companies' determination of benefits.

Signed:____ Date:_________________________

Printed Name____

Parent or Guardian (for minor) ____

ARIZONA INTEGRATIVE MEDICAL CENTER, P.C.
8144 E. Cactus Rd. Ste # 820
Scottsdale, AZ 85260
Phone: (480) 214-3922
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Patient Intake Form

Patient Name:______________________________ **Date of Birth**:______________

List in order of importance what your problems are:
1)______________________________
2)______________________________
3)______________________________
4)______________________________
5)______________________________

Date of last blood work performed and by which physician: ______________________________
____

Family History

	Father	Mother	Siblings	Spouse	Grandparents	Children
Age (if living):	________	________	________	________	________	________
Age (if passed):	________	________	________	________	________	________
Reason for Death:	________	________	________	________	________	________
Cancer Type:	________	________	________	________	________	________
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalization, including date occurred:
1)______________________ 4)______________________
2)______________________ 5)______________________
3)______________________ 6)______________________

Please note when and why you have had each of the following performed:
X-Rays:______________________ MRI/Cat Scans:______________________
Ultrasounds: ______________________ Accidents:______________________
TB Test:______________________ HCV:______________________
HIV:______________________ Last Dental Visit:______________________
Last Eye Exam:______________________

Did you have the following:
Disease (**D**), I**mmunized** (**I**), or **Neither** (**N**)

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N
Tetanus: D I N **Whooping Cough**: D I N **Hemophilus** (Hib): D I N **Hebatitis B**: D I N
German Measles: D I N **Any vaccination reactions**:____
____

List **Yes** (**Y**), **No** (**N**), or **Past** (**P**) regarding use of the following:

Ant-acids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & numbers of years**:________
Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day**: ________________________
Soda Pop: Y N P **Ounces per day**:________ **Alcohol**: Y N P **How often & how much**:___________
Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P
Recreational Drugs: Y N P **Any Drug Addictions**: Y N P **Any Drug Treatment**: Y N P

List all Prescription Medicines and Nutrient Supplements/Herbs you are currently taking and dosage:
____
____

Review of System:

Present Weight: _______________ **Weight one year ago**: _______________ **Height**: ________________
Maximum weight and when:________________ **Minimum weight and when** (as adult):________________
Ideal weight:__________________

Regarding the next section: Please circle (**Y**) if you have a symptom **NOW**, (**N**) if you've **NEVER** had the symptom, and (**P**) if you had the symptom in the **PAST**.

Good Energy: Y N P **Fatigue**: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst?____________________________
If you have fatigue, can you do what you need to during the day? Y N

Skin				
Rash:	**Y N P**		**Color Change:**	**Y N P**
Hives:	**Y N P**		**Lump:**	**Y N P**
Psoriasis/Eczema:	**Y N P**		**Itchy Skin:**	**Y N P**
Dry Skin:	**Y N P**		**Warts/Moles:**	**Y N P**
Skin Cancer:	**Y N P**		**Perspiration:**	**Y N P**
Head				
Headache:	**Y N P**		**Migraine:**	**Y N P**
Dandruff:	**Y N P**		**Head Injury:**	**Y N P**
Oil/Dry Hair:	**Y N P**		**Hair Loss:**	**Y N P**

Nose				
Frequent Colds:	**Y N P**		**Nosebleeds:**	**Y N P**
Congestion:	**Y N P**		**Post Nasal Drip:**	**Y N P**
Polyps:	**Y N P**		**Seasonal Allergies:**	**Y N P**
Eyes				
Dry/Watery:	**Y N P**		**Blurry Vision:**	**Y N P**
Double Vision:	**Y N P**		**Cataracts:**	**Y N P**
Glaucoma:	**Y N P**		**Styes:**	**Y N P**
Strain:	**Y N P**		**Discharge:**	**Y N P**
Itchy:	**Y N P**		**Dark under Eye:**	**Y N P**
Mouth/Throat				
Canker Sores:	**Y N P**		**Cold Sores:**	**Y N P**
Sore Throat:	**Y N P**		**Gum Disease:**	**Y N P**
Dentures:	**Y N P**		**Cavities:**	**Y N P**
Loss of Taste:	**Y N P**		**Hoarseness:**	**Y N P**
Neck				
Stiffness:	**Y N P**		**Swollen Glands:**	**Y N P**
Full Movement:	**Y N P**		**Tension:**	**Y N P**
Respiratory				
Cough:	**Y N P**		**TB:**	**Y N P**
Shortness of Breath (w/exertion):	**Y N P**		**Bronchitis:**	**Y N P**
Shortness of Breath (sitting):	**Y N P**		**Pneumonia:**	**Y N P**
Shortness of Breath (lying down):	**Y N P**		**Asthma:**	**Y N P**
Wheezing:	**Y N P**		**Painful Breathing:**	**Y N P**
Cardiovascular				
High Blood Pressure:	**Y N P**		**Rheumatic Fever:**	**Y N P**
Low Blood Pressure:	**Y N P**		**Murmurs:**	**Y N P**
Arrhythmias:	**Y N P**		**Palpitations:**	**Y N P**
Edema:	**Y N P**		**Chest Pains:**	**Y N P**

Urinary Tract				
Incontinence:	Y N P		Pain w/ Urination:	Y N P
Frequent Infections:	Y N P		Kidney Stones:	Y N P
Urgency:	Y N P		Discharge/Blood:	Y N P
Gastrointestinal				
Heartburn:	Y N P		Bowel Movements Per Day:________	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/ Constipation	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease:	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer:	Y N P
Male Genitalia				
Testicular Pain/ Swelling	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.'s:	Y N P
Discharge:	Y N P		Prostate Disease/ Symptoms	Y N P
Impotency:	Y N P		Sexual Orientation:	Hetero G L T BI
Last Prostate Exam:			Prostate Exam Results:	
Female Genitalia				
Age of 1st Period:			Period Occurs How Often:	
Length of Periods:			Heavy Menstrual Bleeding:	Y N P
# of Births:			Menstrual Pain:	Y N P
# of Abortions:			Food Cravings:	Y N P
# of Pregnancies:			Dexa Scan:	Y N P
# of Miscarriages:			PMS:	Y N P
Last Pap Smear:			Healthy Libido:	Y N P
-Diagnosis:			Sexually Active:	Y N P
Any Abnormal Paps:	Y N P		Vaginitis:	Y N P
-When:			S.T.D.'s:	Y N P
Menopausal since age:			Pain w/Intercourse:	Y N P
Use of Hormones:	Y N P		Dry Vagina:	Y N P
Type of Hormones Used:			Mammography:	Y N P
Menstrual Cramping:	Y N P		-What were results	

Please list any birth control used and state age when method was used:________________________

____

Musculoskeletal				
Weakness:	**Y N P**		**Arthritis:**	**Y N P**
Stiffness:	**Y N P**		**Leg Cramps:**	**Y N P**
Tremors:	**Y N P**		**Pain:**	**Y N P**
Nervous				
Paralysis:	**Y N P**		**Sciatica:**	**Y N P**
Tingling/ Numbness:	**Y N P**		**Carpal Tunnel Syndrome:**	**Y N P**
Seizures:	**Y N P**		**Fainting:**	**Y N P**
Mental/Emotional				
Depression:	**Y N P**		**Anger/Irritability:**	**Y N P**
Suicidal:	**Y N P**		**High-Strung/Tense:**	**Y N P**
Anxiety:	**Y N P**		**Fear/Panic:**	**Y N P**
Eating Disorder:	**Y N P**		**Psych Hospitalization:**	**Y N P**

Exercise

How often do you exercise?_________________ What type of exercise?__________________________
For how long?______________________________ Hobbies:_______________________________________
____

Sleep

How many hours per night?_____________ If you wake up frequently, what is the reason?___________
____

Nightmares:	**Y N P**	**Wake Refreshed:**	**Y N P**	**Must nap during day:**	**Y N P**
Sleep Walk:	**Y N P**	**Grind Teeth:**	**Y N P**	**Snore**	**Y N P**

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution were you exposed to? ____
____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic material? If so, please list: ____
____

Have you ever had health problems when you put in new carpet, painted your home, had new cabinets or did other refurbishing? If so, please list:____
____

Are you particularly sensitive to perfumes, gasoline or other vapors? If so, please list: _______________
____

Do you use pesticides, herbicides, or other chemicals around your home? If so, please list: ___________
____

Social Life

Hours worked per week:___________________ Highest level of education: _______________________
What is your greatest health concern and how does it limit you?_________________________________
____

Enjoy Job:	**Y N P**	**How committed are you towards making valuable changes?**	**Little Moderately Very**
Active Spiritual Practice:	**Y N P**	**History of Sexual, Mental/ Emotional, Physical Abuse? If so, please state age and by whom:**	