SYMMETRIA INTEGRATIVE MEDICAL
RELIEF | REPAIR | RESTORE

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Ph: 360-659.6554 Fax: 360-653.4882

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Ph: 360-474-9900 Fax: 360-474-8064

COMPREHENSIVE HEALTH HISTORY FORM

PATIENT INFORMATION

Patient Name: _____
(last) *(first)* *(middle initial)*

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Best Contact: □ Phone □ Text □ Email

Email: _____ Sex: □ M or □ F

SS#: _____ DOB: _____ Age: _____

Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship: _____

Home Ph:(_____) _____ Cell Ph:(_____) _____

How Did You Hear About Us?

□ Referral: _____
□ Direct Mail □ Internet □ Magazine □ TV
□ Other: _____

Name of person(s) who we can disclose or release medical information to.

_____
_____

ACCIDENT INFORMATION

Do you currently have an active accident claim? □ Yes □ No Date: _____

Type of Accident: □ Auto □ Work □ Home □ Other _____

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Work Comp □ Other _____

Attorney Name: *(if applicable)*

_____

PRIMARY CARE

Primary Care Physician's Name: _____

Clinic Name: _____ Phone #: _____

I allow my health progression to be shared with my primary care physician:

□ Yes □ No

Do you have current X-rays at another office or clinic?

□ Yes □ No

INSURANCE INFORMATION

Who is responsible for this account?

□ Self □ Other: _____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient covered by additional Insurance? □ Yes □ No

Subscribers Name: _____

DOB: _____ SS#: _____

Relationship to Patient: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have) I am ultimately responsible to pay **Symmetria Integrative Medical** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient Date

Name: _____ Date: _____
Last First

CURRENT MEDICATIONS ☐ Check if list attached

☐ If a list is attached, please check this box.

Medication	Dosage/How Long	For what condition?

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No Describe: _____

_____

CURRENT HERBAL/VITAMINS

Name	Dosage/How Long	For what condition?

ARE YOU CURRENTLY USING THE FOLLOWING MEDICATIONS?

NSAIDS (Advil, Aleve, etc.), motrin, or aspirin? ☐ Yes ☐ No
If yes, for how long? _____

Tylenol? ☐ Yes ☐ No
If yes, for how long? _____

Acid blocking drugs (i.e. Tagament, Zantac, Prilosec)? ☐ Yes ☐ No
If yes, for how long? _____

Long term antibiotics? ☐ Yes ☐ No
If yes, for how long? _____

Steroids (i.e. Prednisone, Nasal Allergy Inhalers)? ☐ Yes ☐ No
If yes, for how long? _____

ALLERGIES:

Do you have allergies to: ☐ Medications ☐ Supplements &/or ☐ Foods?

Allergy	Reaction(s)

Other:_____

_____

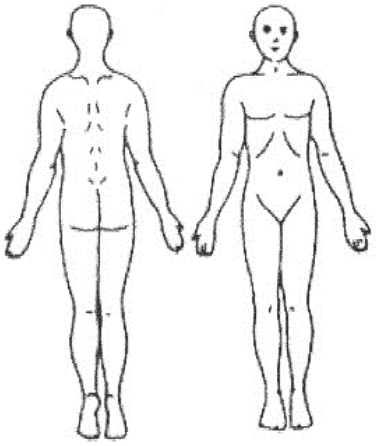
_____

_____

CURRENT CONDITIONS

Please Circle & Label on the Diagram the CURRENT Areas of Discomfort with the following key:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins & Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling



AREA(S) OF CONCERN:

If you had a magic wand and could erase 3 health problems, what would you choose to erase?

1. _____
2. _____
3. _____

What do you hope to achieve in your visit with us?

_____

_____

AREA OF CONCERN # 1:

When did the condition(s) begin? _____

Has it occurred before? ☐ Yes ☐ No When?_____

Is the condition getting worse? ☐ Yes ☐ No ☐ Unknown

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip/Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause

☐ Other: _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services

☐ None ☐ Other: _____

AREA OF CONCERN # 2:

When did the condition(s) begin? _____

Has it occurred before? ☐ Yes ☐ No When?_____

Is the condition getting worse? ☐ Yes ☐ No ☐ Unknown

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip/Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause

☐ Other: _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services

☐ None ☐ Other:

Name: _____ Date: _____
Last First

HEALTH HISTORY

Please **check** all that apply (past/present) & **CIRCLE** all CURRENT conditions:

___ ADD
___ AIDS/HIV
___ Alcoholism
___ Allergies
___ Alzheimer's
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Atopic Dermatitis
___ Bed Wetting
___ Bleeding Disorders
___ Blood Clot
___ Blood Transfusion
___ Breast Lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Cerebral Palsy
___ Chemical Dependency
___ Chest Pain
___ Chicken Pox
___ Cholera
___ Chronic Fatigue Syndrome
___ Crohn's/Colitis
___ CRPS (RSD
___ Constipation
___ CVA (Stroke)
___ Cystic Kidney Disease
___ Depression
___ Diabetes (*insulin*)
___ Diabetes *(non insulin*)
___ Ear Infections
___ Eating Disorder
___ Eczema
___ Fetal Drug Exposure
___ Fibromyalgia
___ Fractures
___ Gallbladder Disorder
___ Goiter
___ Gallstones
___ German Measles
___ Glaucoma
___ Gonorrhea
___ Gout
___ Headaches
___ Heart Attack
___ Heart Disease
___ Heart Failure
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes/Lesions /Shingles
___ High Blood Pressure
___ High Cholesterol
___ Hormone Replacement
___ Hypoglycemia
___ Influenza Pneumonia
___ IBS (*Irritable Bowel Syndrome*
___ Jaundice
___ Kidney Stones
___ Liver Disease
___ Lung Disease
___ Lupus Erythema (*Discoid*)
___ Lupus Erythema (Systemic)
___ Malaria
___ Measles
___ Migraine Headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Pacemaker
___ Parkinson's disease
___ Pinched Nerve
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Prostate Problems
___ Prosthesis
___ Psoriasis
___ Psychiatric Care
___ Rheumatic Fever
___ Rheumatoid Arthritis
___ Scarlet Fever
___ Scoliosis
___ Seizure Disorder
___ Sickle Cell Anemia
___ Sinusitis
___ Sleep Apnea
___ Spina Bifida
___ STD
___ Stroke
___ Suicide Attempt(s)
___ Swelling Feet
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors, Growths
___ Typhoid Fever
___ Ulcers
___ Unspec. Pleural Effusion
___ Vaginal Infections
___ Vertigo
___ Whooping Cough
___ Other: _____
_____

WORK HISTORY

Labor Activity: □ Light □ Moderate □ Heavy □ Sedentary

Work Activity Postures: □ Bending □ Climbing □ Kneeling □ Pulling □ Pushing □ Reaching □ Sitting □ Standing □ Twisting □ Walking □ Computer □ Repetitive

Work Activity Level: □ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed

Work Environment: □ Difficult □ Enjoyable □ Relaxed □ Stressful

Hours per week _____ Mostly: □ Sitting □ Walking □ Standing

LIFESTYLE HISTORY

Exercise Level: □ Inactive □ Light Activity □ Moderate Activity □ Heavy Activity □ Vigorous Activity

Please check all that apply:

□ Tobacco – Type: _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? □ Yes □ No

□ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have you previously used recreational drugs?

□ Yes □ No If yes, what types/method (IV, inhaled, smoked, etc):

_____

_____

MAJOR INJURIES & FRACTURES:

Have you had any of the following happen in your past?

□ Motor Vehicle Collision □ Severe Fall □ Broken bone/Fractures
□ Head injury □ Sports injury □ Injury to Spine □ Soft Tissue Injury

Injury Type:	**When: Year(s) or Age**

SURGERIES:

Please list all past surgeries and year(s) preformed:

Surgery Type:	**When: Year(s)**

Name: _____ Date: _____