**Birmingham Integrative Health, P.C.**
**Patient Information**

**Patient's Full Name:** _____

**Date of Birth:** _____ **Social Security Number:** _____

**Address:** _____

**City:** _____ **State:** _____**Zip:**_____

**Home #:** _____ **Cell #:**_____

**Work/Alt #:** _____

**Preferred Appointment Reminder Method:** (Circle)

Home Phone Cell Phone Work/Alt Phone

**If PATIENT is a MINOR**

**Parent's Name:** _____

**Parent's Phone Number:** _____

**Emergency Contact**

**Name:** _____ **Relationship:** _____

**Phone Number:** _____

**Pharmacy (Name, Phone Number)**

**Regular:** _____

**Compounding:** _____

**Mail In:** _____

**Insurance Information**

**Insurance Name:** _____

**Policy Holder's Name:** _____ **Relationship:** _____

**Date of Birth:** _____ **Social Security** (billing purposes)**:** _____

**Policy Holder's Phone Number:** _____ **Effective Date:** _____

**Group Number:** _____ **Policy/Member Number:** _____

**Copay:** _____ **Deductible:** _____

**Birmingham Integrative Health, P.C.**
**Patient Information**

## Personal Medical History: (Circle/Explain)

Acid Reflux
ADHD
Allergies, Seasonal
Anemia: _____
Anxiety
Arrhythmia: _____
Arthritis: _____
Asthma
Cancer: _____
Dementia
Depression
Diabetes: _____
GI Disease: _____
Headaches/Migraines
Heart Attack (MI)
Heart Disease: _____
High Blood Pressure
High Cholesterol
Kidney Disease: _____
Liver Disease
Lung Disease: _____
Osteopenia/Osteoporosis
Parkinson's
Seizure Disorder: _____
Sleep Apnea
Stroke
Thyroid Disease
Other: _____

| | | |
|---|---|---|
| **Last Menstrual Period** | **Date:** | **Normal Abnormal** |
| **Colonoscopy** | **Date:** | **Normal Abnormal** |
| **Mammogram** | **Date:** | **Normal Abnormal** |
| **Bone Density** | **Date:** | **Normal Abnormal** |
| **Pap** | **Date:** | **Normal Abnormal** |

## Family History

| | **Mother** | **Father** | **Grandparents** | **Siblings** | **Children** |
|---|---|---|---|---|---|
| **CAD** | | | | | |
| **Cancer: Type** | | | | | |
| **Dementia** | | | | | |
| **Diabetes: I, II** | | | | | |
| **High Blood Pressure** | | | | | |
| **High Cholesterol** | | | | | |
| **Stroke** | | | | | |
| **Thyroid Disease** | | | | | |

**Surgical History** Please Include Dates

_____
_____
_____
_____

**Birmingham Integrative Health, P.C.**
**Patient Information**

**Social History**

**Marital Status:** Married Single Divorced Widowed
**Number of Children:** _____
**Smoker:** No, never No, Quit _____ Yes, Type_____ Amount _____ Years_____
**Alcohol:** Never Quit_____ Rarely Weekly Daily
**Recreational Drugs:** _____
**Sexually Active:** Yes No

**Please list medications, vitamins, herbs, supplements you are currently taking**

| Name | Strength | How often do you take it? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Are you allergic to any medications?**

No Known Yes (please specify and include what type of reaction you had)

_____

_____

## What is the reason for your visit today?

**__ Get established with a primary care physician**

**__ Hormone imbalance**

**__ Thyroid Disorders**

**__ Weight Loss**

**__ Fatigue**

**__ Trouble Sleeping**

**__ Acupuncture, what problem? _____**

**__ Sick _____**

**__ Other _____**

**_____**

**_____**