

WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City State Zip

Phone # (M) _____ (H) _____ (W) _____

Can we call you at work? Yes No Can we email you reminders, events, and newsletters? __Yes __No

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Race: Caucasian African American Asian Native American Latin American Other _____

Ethnicity: Hispanic Latino Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Mobile #: _____

Phone #: (H) _____ (W) _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|----------------------------------------------|------------------------------------------------|---------------------------------------------|------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

- | | | |
|----------------------------------------------|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | |

Do you exercise: Never Daily Weekly Walks Runs Swims

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

Review of Systems

SIGNATURE (X) _____ **DATE** _____

Please mark if you have experienced any of these symptoms within the last month:

Y	N	Neurological
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
Eyes/Ear/Nose/Throat		
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Twitching eye lids
___	___	Sensitivity to light
___	___	Sensitivity to smells, chemicals
___	___	Gingivitis
___	___	Nose bleeds
___	___	Sensitivity to sound
___	___	Bad breath
___	___	Mouth sores
Cardiovascular		
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
Respiratory		
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
GI		
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
Musculoskeletal		
___	___	Joint Pain
___	___	Arthritis
___	___	Frequent muscle cramping
___	___	Muscle Aches
___	___	Pain in shoulders or upper back
___	___	Muscle twitching

Y	N	Skin
___	___	Eczema
___	___	Dry skin
___	___	Receive static shock more often
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
___	___	Low Body Temp.
___	___	Persistent fungal or viral infections, including athletes foot, warts, jock itch or candidiasis
Genitourinary		
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
___	___	Excessive thirst or frequent urination
Emotional/Mental		
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
___	___	Indecisiveness
Energy		
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
Weight		
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

NEUROLOGICAL/TOXICITY QUESTIONNAIRE

For any YES answer, please include details.

Heavy Metals

- | | | |
|----------------------------------------------------------------------------------------------------------------|----|-----|
| 1. Do you have amalgam (silver) fillings in your teeth?
Comment: _____ | NO | YES |
| 2. Have you ever had them in the past?
Comment: _____ | NO | YES |
| 3. Did your mother have amalgam fillings when pregnant with you?
Comment: _____ | NO | YES |
| 4. Have you ever worked in a dental office? If so, how long?
Comment: _____ | NO | YES |
| 5. Have you had any dental crowns, bridges, root canals, dry sockets or extractions?
Comment: _____ | NO | YES |
| 6. Do you have any dental implants or other metal in your mouth?
Comment: _____ | NO | YES |
| 7. Did you wear contact lenses during the 1980's or early 1990's?
Comment: _____ | NO | YES |
| 8. Did you take oral contraceptives during the 1980's or early 1990's?
Comment: _____ | NO | YES |
| 9. Did you receive yearly flu shots or have you recently received a flu shot or vaccination?
Comment: _____ | NO | YES |
| 10. Have you noticed any adverse reactions to these shots?
Comment: _____ | NO | YES |
| 11. Do you have any tattoos with red ink?
Comment: _____ | NO | YES |
| 12. Do you eat large amounts (more than twice a week) of tuna, shark, or Atlantic salmon?
Comment: _____ | NO | YES |
| 13. Does your occupation involve soldering, metal salvage, old home repair?
Comment: _____ | NO | YES |
| 14. Have you remodeled a home built before 1978?
Comment: _____ | NO | YES |
| 15. Have you lived in a home built before 1978 for more than 5 years?
Comment: _____ | NO | YES |
| 16. Have you ever worn cosmetics containing Kohl?
Comment: _____ | NO | YES |

SIGNATURE (X) _____ **DATE** _____

General Toxicity

17. Have you ever lived near, on or by a golf course, freeway or tension wires? NO YES
Comment: _____
18. Have you ever had any chemical exposures? NO YES
Comment: _____

Mold

- How old is the house you are living in? _____ How long have you lived there? _____
19. Do you see mold growing at home, work or school? NO YES
Comment: _____
20. Have you ever had water damage at home, work or school? NO YES
Comment: _____
21. Does your home, workplace or school have a damp or mildew smell? NO YES
Comment: _____
22. Does spending time in your basement cause or worsen your symptoms? NO YES
Comment: _____
23. Does your basement ever get wet?? NO YES
Comment: _____
24. Does spending time in a different location cause a decrease in your symptoms? NO YES
Comment: _____

Lyme Disease

25. Have you ever been diagnosed with Lyme disease? NO YES
Comment: _____
26. Have you ever been bitten by a tick or recluse spider? NO YES
Comment: _____
27. Have you ever seen a bulls-eye rash appear on any part of your body? NO YES
Comment: _____
28. Did the bulls-eye rash appear shortly after following a tick, spider bite? NO YES
Comment: _____
29. Was your mother ever diagnosed with Lyme Disease? NO YES
Comment: _____
30. Do you frequently go camping, hunting or are you involved in outdoor activities? NO YES
Comment: _____

SIGNATURE (X) _____ **DATE** _____

Health

31. Any family been diagnosed with fibromyalgia, chronic fatigue or chemical sensitivity? NO YES
Comment: _____
32. Do you have any history of kidney dysfunction? NO YES
Comment: _____
33. Is there a family history of breast, uterine, cervical or other female cancers? NO YES
Comment: _____
34. Is there a family history of PMS, fibroids or ovarian cysts? NO YES
Comment: _____
35. Do you have any history of heart disease, myocardial infarction (heart attack), etc? NO YES
Comment: _____
36. Are you currently having any thoughts of suicide? NO YES
Comment: _____
37. Have you ever been diagnosed with bipolar disorder, schizophrenia or depression? NO YES
Comment: _____
38. Do you have a history of strokes? NO YES
Comment: _____
39. Have you ever been diagnosed with diabetes mellitus? NO YES
Comment: _____
40. Have you ever been in an auto accident, fallen or received a major physical injury? NO YES
Comment: _____
41. Are you in menopause? NO YES
Comment: _____
42. Do you have any allergies to food or medication? NO YES
Comment: _____

SIGNATURE (X) _____ **DATE** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Revolution Health LLC.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can
request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my
answering machine or with another person in my home. I may make a request of an alternative means of
communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may
speak with the Privacy Officer about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date