Med Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

Patient Intake Form

Personal Information (please print)

Name: _____ D.O.B.: _____
Last, First, Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Gender: ☐ Male ☐ Female

Medical Condition(s)

Please select the condition(s) for which you are seeking a medical marijuana certification for:

☐ Headache	☐ Parkinson's	☐ Cystic Fibrosis
☐ Facial / Nerve Pain	☐ Amyotrophic Lateral Sclerosis	☐ Glaucoma
☐ TMJ with Headaches	☐ Ulcerative Colitis	☐ Muscular Dystrophy
☐ Chronic Neuropathic Pain with Degenerative Spinal Disorders	☐ Osteogenesis Imperfecta	☐ Crohn's Disease
☐ Osteoarthritis of the Spine/Degenerative Joint Disease	☐ Amyotrophic Lateral Sclerosis	☐ Sickle Cell Disease
☐ Fibromyalgia	☐ Cerebral Palsy	☐ Wasting Syndrome
☐ Sciatica/Pain running down one or both legs	☐ Terminal Illness Requiring End-Of-Life Care	☐ Cachexia
☐ Post Laminectomy Syndrome	☐ Uncontrolled Intractable Seizure Disorder	☐ HIV/AIDS
☐ Failed Neck or Back Surgery	☐ Post-Traumatic Stress Disorder (PTSD)	☐ Multiple Sclerosis
☐ Severe Rheumatoid Arthritis	☐ Post Herpetic Neuralgia	☐ Cancer
☐ Damage to the Nervous Tissue of the Spinal Cord	☐ Hydrocephalus with Intractable Headache	☐ Epilepsy
☐ Complex Regional Pain Syndrome	☐ Other: _____	

What previous treatments have you tried for the above-mentioned condition(s)?

Is anyone else treating you, or diagnosed you with any of the conditions mentioned above?

Have you ever been prescribed medical marijuana? ☐ Yes ☐ No

_____ _____
Patient Signature Date

HEALTH HISTORY
Confidential

Patient Name_____ Today's Date _____

Age_____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name Phone

ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease		Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

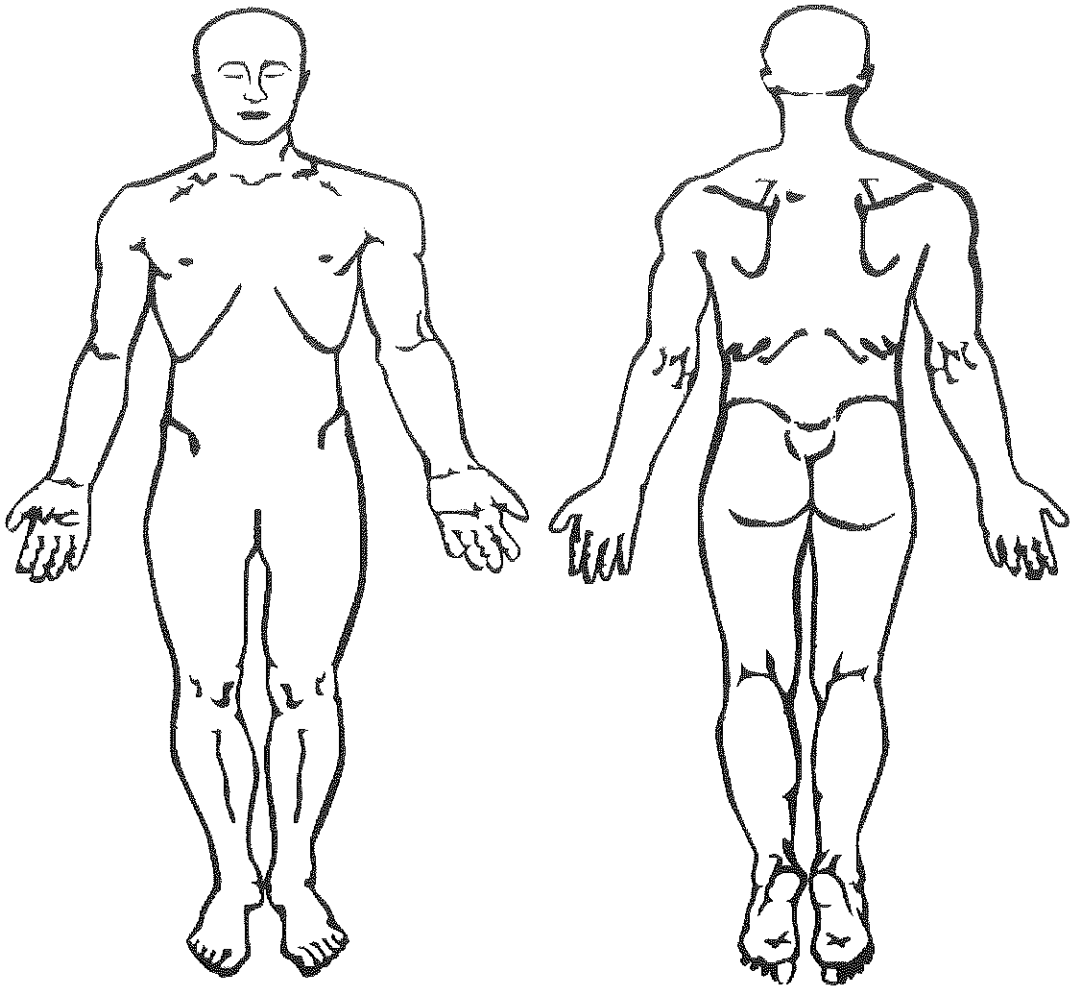
Reviewed By — Date

PAIN DIAGRAM

Date: _____ Name: _____

Use the body diagram below to indicate the location of any of the sensations listed. Mark the areas on the drawings with the symbol that best describes the sensation that you feel.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
AAAA	====	OOOO	.....	////	xxxx
AAAA	====	OOOO	.....	////	xxxx



Instructions: Please circle the number that is associated with each complaint.

no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

iMed Chiropractic
INTEGRATED MEDICAL OF FAIRFIELD

527 Tunxis Hill Rd. Fairfield, CT 06825
T 203.333.7788 F 203.366.7566

Patient Questionnaire

Patient Name_____ Date_____

1. Do you ***currently*** experience any numbness/tingling/pins and needles in to your arms & hands or legs & feet?

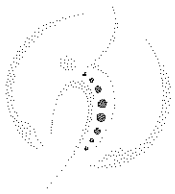
Yes / No

2. Do you experience any numbness or tingling at ***any time*** during the day and/or during the night when in bed?

Yes / No

3. How long has it been since you have experienced any of these symptoms?

_____



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_____

_____

_____

Print Facility Name, Phone Number, Fax Number and Contact Person

I, the undersigned hereby authorize the release of my Medical Records to Integrated Medical Centers in order to help in my diagnosis and / or treatment.

I understand that Integrated Medical Centers will protect my privacy in accordance with the government's rules and regulations stated in their Notice of Privacy Act which is available upon my request.

_____ _____

Print Patient Name Date

_____

Patient Signature

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____