INTEGRATIVE HEALTH
LEWISTON FAMILY CHIROPRACTIC, LLC

CONFIDENTIAL PATIENT INFORMATION

Name (First/M.I./Last): _____

What would you preferred to be called? _____

Cell Phone: _____ Cell Phone Carrier: _____

Work Phone: _____ May we send you text reminders: ____YES ____NO

Home Phone: _____ SS #: _____

Address: _____

E-Mail: _____

Age: _____ Birth Date: _____ / _____ / _____ (Circle one): Male / Female

Marital Status (Circle): Single / Married / Widowed / Divorced # of Children: _____

Race (Circle): White / American Indian or Alaska Native / Black or African American / Other

Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Occupation: _____

Employer: _____

Spouse Name: _____

Spouse Occupation/Employer: _____

Spouse Home/Cell/Work Phone: _____

Emergency Contact: _____Phone: _____

Have you ever filed for Bankruptcy or Medical Malpractice (circle): Yes / No When: _____

How did you hear about our clinic? _____

At this time I choose to decline receipt of my clinical summary after EVERY visit – I will request a clinical summary when necessary.

Patient Signature: _____ Date: _____

Guardian/ Parent/ Spouse Signature Authorizing Care: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Aesthetics & IV Nutritional Therapy
Kurt A. Bailey DC, NP-C
Kasey Landrus RN

208.799.3333 Phn

Integrative Health of Lewiston
3510 12th Street, 200
Lewiston, ID 83501

208.799.3375 Fx

Name_____ Phone_____ Email_____

What areas of the body bother you most_____

How long has this bothered you?_____

What are you hoping CoolSculpting can do for you? Clothes to fit better _____ Special Event _____

Feel more Confident_____ Other _____

Have you heard of CoolSculpting before? Yes _____ No _____

Have you considered other treatments/procedures? Yes _____ No _____

Botox _____ Filler/ Juvederm _____ Kybella _____ Hydrafacial ____

Laser Hair Removal _____ ZO Skin Health _____ VitaminDrip _____

What facial products are you currently using? Medical Grade _____ Over-the-Counter _____

What type of programs have you tried?

Weight Watchers, Jenny Craig, Nutrisystem _____ Diet Pills_____ Code Red_____

Cosmetic Surgery_____ Other _____

On a scale of 1 to 10, (10 being the highest) how important is it to lose inches?_____

How will your life improve when you achieve the results you've been looking for? _____

_____

At Integrative Health, we are committed to supporting you in achieving your personal body goals, as well as assisting you in reaching your own perfect balance in wellness. With the body contouring programs we offer with CoolSculpting, to ensure optimal results and enjoy perminent benefits, it is imperative that you consistently dedicate time and effort to maintaining the following:

For the duration of the CoolSculpting treatment program:

1. Drink the required amount of water daily (Half of your body weight in ounces).
2. Brisk exercise (walking, swimming, etc) for a minimum of 20 minutes daily.
3. Eat healthy as a daily practice.
4. Take the recommended nutritional supplements daily.
5. Wear body compression garment for two hours/day.

I agree to the above terms in support of my wellness in optimal success with CoolSculpting treatment program, in addition to the home instructions.

Signature_____ Date_____

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Lewiston Family Chiropractic, LLC

Tobacco: ☐ Yes ☐ No ☐ Quit ☐ Smokeless Packs per day: _____# of yrs: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Daily How much per week? _____

Recreational Drugs: ☐ No ☐ Yes ☐ Amphetamines ☐ Other: _____

Caffeine: ☐ Yes ☐ No How much per day? _____

Family History:					
	Father	☐ Deceased	☐ Living	Age: _____	Medical Problems: _____
	Mother	☐ Deceased	☐ Living	Age: _____	Medical Problems: _____
	Siblings	☐ Deceased	☐ Living	Age: _____	Medical Problems: _____
	Spouse	☐ Deceased	☐ Living	Age: _____	Medical Problems: _____

Please check if you <u>have</u> or <u>had</u> any of the following:

MUSCLES / SKELETAL
- ☐ Arthritis
- ☐ Polio
- ☐ Joint infection, pain, swelling
- ☐ Loss of motion in joints
- ☐ Bone fractures
- ☐ Spine abnormality
- ☐ Brittle or soft bones
- ☐ Bursitis/tendonitis

HEART / CARDIOVASCULAR
- ☐ Chest pain
- ☐ Abnormal heartbeat
- ☐ High/low blood pressure
- ☐ Fingers/toes sensitive to cold
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Rheumatic fever

BREATHING / RESPIRATORY
- ☐ Breathing problems
- ☐ Excessive cough
- ☐ Night sweats
- ☐ Allergy/cold symptoms
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ TB

EARS / HEARING
- ☐ Loss of hearing
- ☐ Buzzing or noise in ear

NEUROLOGICAL / MIGRAINES
- ☐ Severe/frequent headaches
- ☐ Dizziness/fainting spells
- ☐ Seizures/convulsions
- ☐ Shaking/twitching limbs
- ☐ Paralysis of limbs

NOSE / THROAT
- ☐ Hoarseness
- ☐ Blocked nasal passages
- ☐ Nose bleeds
- ☐ Difficulty swallowing
- ☐ Allergies

URINARY
- ☐ Bloody urine
- ☐ Painful/difficult urination
- ☐ Kidney/urine problems
- ☐ Flank pain

STOMACH / INTESTINES
- ☐ Frequent nausea/ vomiting
- ☐ Bloody vomitus
- ☐ Stomach, abdominal, bowel pain
- ☐ Recurring diarrhea
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Frequent/severe constipation
- ☐ Diabetes, gallbladder disease
- ☐ Hernia

EYES / VISION
- ☐ Eye pain or redness
- ☐ Loss or change of vision
- ☐ Double or blurred vision
- ☐ Corrective glasses/contacts

EMOTIONAL
- ☐ Emotional illness
- ☐ Depression
- ☐ Anxiety
- ☐ Feelings of worthlessness
- ☐ Physical abuse
- ☐ Frequent nightmares
- ☐ Hysterical attacks
- ☐ Difficulty sleeping

MALE
- ☐ Abnormality of testicles
- ☐ Varicocele
- ☐ Difficulty in sexual function
- ☐ Genital pain
- ☐ Plastic Surgery

FEMALE
- ☐ Breast pain
- ☐ Breast implants/reduction
- ☐ Uterine fibroids/tumors
- ☐ Painful menses/excessive bleeding
- ☐ Genital pain
- ☐ Difficulty in sexual function
- ☐ Plastic Surgery

Patient Signature: _____ Date: _____

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Lewiston Family Chiropractic, LLC

Current Family Physician: _____

Current pharmacy / pharmacist: _____

Please list any medications, vitamins or supplements that you are currently taking:

	Medication Name	Dosage	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Please list any known allergies and your reaction to them:

	Allergies	Reaction	Onset Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____