



WELCOME TO ADVANCED INTEGRATED MEDICINE

Intake Paperwork Instructions

******PLEASE KEEP IN MIND THAT THIS IS AN INTEGRATED FACILITY THAT COMBINES MANY DISCIPLINES (I.E., MEDICAL, CHIROPRACTIC AND FUNCTIONAL MEDICINE DOCTORS). SO, WHILE FILLING IN THIS PAPERWORK, CONSIDER ANY AND ALL CURRENT HEALTH ISSUES ******

1. If this visit is due to an auto accident, motorcycle accident or slip and fall, please ask the front desk for alternative paperwork.
2. Please fill out the following forms completely and to the best of your ability.
3. Make sure to initial at the bottom of each of the following forms – where indicated.
4. If you run out of room in any of the sections, make an indication, flip the paper over and finish on the backside.

Thank You So Much!



WELCOME TO ADVANCED INTEGRATIVE MEDICINE

PERSONAL

Patient Name: _____	
Address: _____	
City/State/Zip: _____	
Social Security #: _____	
Gender: F / M	
Marital Status: _____	
Age: _____	
Spouse's Name: _____	
Patient's Birthdate: ___/___/___	
Home Phone: _____	
Work Phone: _____	
Ext: _____	
Cell: _____	
Email: _____	
Emergency Contact: _____	
Phone: _____	Relation: _____
May we ask how you were referred?	

GUARANTOR

Policy Holder: _____	
Address: _____	
City/State/Zip: _____	
Social Security #: _____	
Gender: F / M	Birthdate: ___/___/___
Home Phone: _____	
Employer: _____	
Address: _____	
City/State/Zip: _____	
Work Phone: _____	
_____ YES, I have completed/filed the necessary benefits form.	
Insurance Co: _____	
Call Benefits @ () -	
Contact: _____	Ext: _____
Group Name: _____	Group # _____
ID/Claim #: _____	
Patient is: self spouse child 3rd party	
other: _____	

CASE

Were you in an Auto Accident?		Injury Date: _____	
Were you in a Work related Injury?		Injury Date: _____	
Will you be utilizing medical benefits?			
NO Insurance	Insurance	_____ Fund	Auto/Accident Ins
Medicaid/Medical	Medicare	Government	Work Comp Ins
Attorney Name _____			
Attorney Phone Number _____			
Paralegal You Spoke With _____			
Paralegal Email Address _____			
Do You Have Med Pay? Yes No			
If Yes: Claim Number _____			
Adjuster Phone Number _____			
Adjuster Name _____			
Do you have pictures of your accident? Yes No			
If Yes: Please email to aimeicine@bellsouth.net			
Daily Activity/Occupation: _____			

_____ YES, I will pay my portion at the time of service.
 _____ YES, this office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment. Specifically, I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatment(s) and performance of diagnostic procedures. I grant my consent for treatment for myself, or my minor children/dependent listed above.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to Advanced Integrated Medicine of the "Health Benefits," "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me.

I understand this office only accepts assignment when insurance pays directly.

I fully understand when the insurance company verifies my benefits, it is not a guarantee or authorization to pay on claims submitted. I agree to pay my portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied/unpaid claims. Claims submitted by this office are my responsibility and require my participation to understand all claims settle regardless of my insurance company or assignment of benefits.

PRINT

Patient/Guarantor -PRINT name

x _____ / / _____

Patient/Guarantor - SIGNATURE

Date



Advanced Integrative Medicine Initial Evaluation Questionnaire

Health Complaints You Want Help With (#1 most important - #5 least important)

1. _____ When did it start? _____
2. _____ When did it start? _____
3. _____ When did it start? _____
4. _____ When did it start? _____
5. _____ When did it start? _____

Referring Physician or Facility _____

Additional Physician(s)

Doctor's Name _____ For What Condition _____

Doctor's Name _____ For What Condition _____

Doctor's Name _____ For What Condition _____

_____ Please check here if you ran out of room and continue this section on the back of this page.

Past Medical History (Please check if you have or have had any of the following)

_____ High Blood Pressure	_____ Arthritis	_____ Ulcer/Reflux Disease
_____ Irregular Heartbeat	_____ Herniated Disc	_____ Degenerative Disc Disease
_____ Stroke	_____ Spinal Stenosis	_____ Peripheral Vascular Disease
_____ Back Pain/Neck Pain	_____ Diabetes	_____ Heart Failure/Heart Attack
_____ Blood Clots	_____ Cancer	

Other Significant Medical History _____

Family History

(Please list all that apply to **blood relatives** -father, mother, father’s parents, mother’s parents and siblings)

_____ High Blood Pressure _____ Diabetes _____ Heart Disease
_____ Anxiety/Depression _____ Cancer - Type? _____
_____ Kidney Disease _____ Thyroid Disease _____ High Cholesterol
_____ Stroke _____ Bleeding Disorder _____ Arthritis (RA/OA)

If Blood Relative is Deceased, Please Indicate Cause and Age of Death _____

Other Significant Family Diseases _____

Do You Have a Pacemaker? Yes No Do You Have a Defibrillator? Yes No

Do You Have any Surgical Devices or metal in Your Body? Yes No (Example: Pins, Plates, Screws, etc.)

If Yes, Please Specify Location _____

Past Hospitalizations and/or Surgeries

Procedure or Reason _____ Date of Procedure _____
Procedure or Reason _____ Date of Procedure _____
Procedure or Reason _____ Date of Procedure _____
Procedure or Reason _____ Date of Procedure _____

_____ Please check here if you ran out of room and continue this section on the back of this page.

Social History

Smoking Yes No Alcohol Yes No Occupation _____

Hobbies and Other Activities _____

Marital Status: _____

Medications (Please indicate name, for what condition and how often you take it)
If you brought a list of your prescriptions, please indicate by writing, "See Rx Sheet" below

Allergies (Please indicate if allergy is due to medications or other)

_____ Please check here if you ran out of room and continue this section on the back of this page.

Current Nutritional Supplements
(Please indicate name, for what condition and how often you take it)

_____ Please check here if you ran out of room and continue this section on the back of this page.

Review of Systems

(Please indicate below any symptoms that you've experienced within the last 6 months)

GENERAL

- Fever
- Chills
- Weakness
- Night Sweats
- Weight Gain
- Weight Loss
- Loss of Appetite
- Fatigue
- Loss of Sleep

CARDIOVASCULAR

- Chest Pain
- Angina
- Murmur
- Irregular Heart Beat
- Palpitations
- Extremity Swelling
- Varicose Veins
- Pain with Walking
- Cold Hands or Feet
- High Cholesterol
- High Triglycerides
- High Blood Pressure
- Heart Attacks
- Congestive Heart Failure
- Atherosclerosis

GENITOURINARY

- Frequent Urination
- Difficulty Controlling Urination
- Blood in Urine
- Pain with Urination
- Passage of Stones

ENDOCRINE

- Heat/Cold intolerance
- Thyroid Disease
- Thyroid Removed
- Goiter
- Decreased Energy
- Hands/Feet Cold
- Diabetes Type I or II
- Heat Intolerance
- Adrenal Disease
- Kidney Disease
- Kidney Stones

HEAD

- Headache
- Trauma
- Dizziness
- Vertigo

RESPIRATORY

- Shortness of Breath
- Wheezing/Asthma
- Sputum Production
- Night Sweats
- Cough
- Coughing up Blood
- COPD/Emphysema
- Bronchitis

SKIN/HAIR

- Rash
- Pruritus
- Moles
- Cancer
- Dryness
- Acne
- Eczema
- Psoriasis
- Hair Loss
- Hives
- Rash

BLOOD/LYMPH

- Anemia
- Blood Thinner
- Easy Bruising
- Easy Bleeding
- Lymph Node Swelling
- Lymph Node Pain

ENDOCRINE (MALE)

- Erection Issues
- Prostate Cancer
- Prostate Enlarged
- Sexual Desire Diminished
- UTI's
- Urinary; Dribble, Hesitancy, Frequency

EYES

- Double Vision
- Blurred Vision
- Cataracts
- Discharge
- Glaucoma
- Watery Eyes

GASTROINTESTINAL

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Ulcer
- Blood in Stool
- Abdominal Pain
- Hernia
- Hemorrhoids
- Change in Appetite
- Anal or rectal pain/itching
- Bloating/belching/gas
- Gall Stones
- Reflux
- Hemorrhoids
- Hepatitis/Liver Disease
- IBS
- Elevated Liver Enzymes

MUSCULOSKELETAL

- Muscle Pain
- Muscle Spasm
- Muscle Atrophy
- Back Pain/Stiffness
- Neck Pain/Stiffness
- Joint Pain
- Joint Stiffness
- Weakness
- Fractures
- Carpal Tunnel Syndrome
- Neuropathy
- Osteoporosis/Osteopenia
- Sciatica

ALLERGY/IMMUNOLOGIC

- Sinusitis
- Seasonal Allergies
- Allergy Shots
- Cancer (type: _____)
- Diabetes Type I
- Hashimoto's Thyroiditis
- Grave's Disease
- Lupus
- Multiple Sclerosis
- Rheumatoid Arthritis

ENT

- Loss of Hearing
- Discharge
- Loss of Smell
- Congestion
- Dentures
- Sores
- Gingival Bleeding
- Hoarseness
- Sore Throat
- Difficulty Swallowing
- Jaw Pain

ENDO-GYNECOLOGIC

- Self-Exam
- Masses/Lumps
- Vaginal Discharge
- Nipple Discharge
- Infertility
- Menstruation Irregular
- Painful Intercourse
- PCOS
- Premenstrual Syndrome
- Painful Menstruation
- Fibroid Tumor
- Yeast Infections
- UTI's recurrent
- Bleeding Between Periods
- Endometriosis
- Hot Flashes
- Loss of Sex Drive
- Vaginal Dryness

PSYCHIATRIC

- Anxiety
- Depression
- Hallucinations
- Sleep Disturbance
- Body Image Concerns
- Cravings
- Eat When Nervous
- High Stress
- Mood Swings
- Phobias

NEUROLOGIC

- Loss of Consciousness
- Fainting
- Numbness
- Weakness
- Tingling
- Seizures

Initial _____

Date of Last Mammogram or Breast Thermography _____ N/A

Date of Last Menstrual Period _____ N/A

Date of Last Pelvic Examination _____ N/A

How Would You Rate Your Stress Level? 1 2 3 4 5 6 7 8 9 10 (1=very low, 10=very high)

How does stress affect you? 1 2 3 4 5 6 7 8 9 10 (1=doesn't bother me, 10=it really affects me)

How often do you exercise? Never Rarely Sometimes Regularly Competitively

Is your exercise limited due to any problems with your body? (i.e., pain, fatigue, breathing, etc)
Yes No If Yes, please explain _____

How well do you sleep? (circle all that apply)

Very Well Trouble falling asleep Trouble staying asleep Insomnia Sleep Apnea

How Long has this been happening? _____

How many hours do you sleep per night on average? _____

Do you wake up tired, even if you slept several hours? Yes No How long has this occurred? _____

Do Night Sweats wake you up? Yes No

Do you wake because you have to urinate? Yes No

Do you take sleep aids? Yes No If Yes, how often? _____

Have You Had a Bone Density Study? Yes No If Yes, Please Note Findings, Date and Facility _____

Have You Ever Had Joint Injections or Trigger Point Injections? Yes No If Yes, Please Specify and Record Location _____

Have You Tried Unsuccessfully to Lose Weight in the Past? Yes No If Yes, What Have You Tried? _____

Have You Been Told That You Will Need Knee Replacement Surgery? Yes No

Comments

Please use the area below to communicate anything that you think is important for us to know regarding your health and your health goals

Signature

I certify that the information I have provided Advanced Integrative Medicine is answered accurately to the best of my ability. I will not hold any AIM doctors, or members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Guardian Signature/Parent or Guardian Signature (if patient is under 18 years of age)

_____/_____/_____
Date

Printed name

