Ph: (757) 410-5462

PATIENT INFORMATION FORM

NAME: _____

ADDRESS: _____

_____

_____

HOME TELEPHONE: (_____)_____

CELLULAR TELEPHONE: (_____)_____

WORK TELEPHONE: (_____)_____

EMAIL ADDRESS: _____

BIRTHDATE: _____/_____/_____

NAME OF PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____**PHONE:**_____

REASON FOR VISIT: _____

How did you hear about us (please check):
TV_____ Tidewater Women_____Internet_____Friend_____Other _____

Synergy Integrative Medical Center
Patient Intake form for WOMEN **MR#** _____

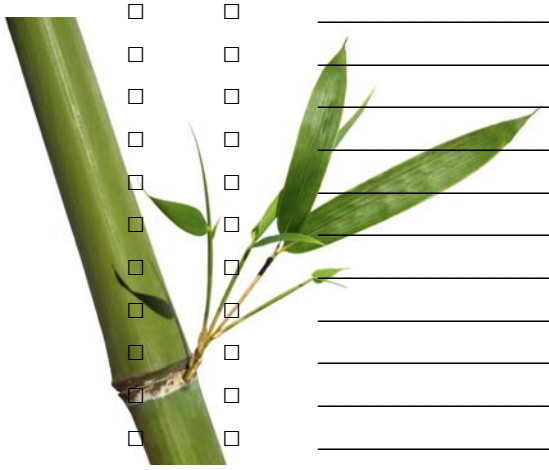
Name _____ **Date** _____

Primary Care Doctor _____ **Referred by** _____

Concern(s): Please rank by priority Example: Headaches	**Onset** 2 years ago	**Frequency** 2x/wk	**Severity** mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit? _____
_____
_____
_____

Illnesses – yours & your family's	**Self**	**Family**	**List family members who have had these illnesses**
Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____
Cancer	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Lung disease	☐	☐	_____
Hepatitis	☐	☐	_____
Digestive diseases	☐	☐	_____
Seizures	☐	☐	_____
Thyroid disease	☐	☐	_____
Mental disorders	☐	☐	_____
Osteoporosis	☐	☐	_____
Other _____	☐	☐	_____
Other _____	☐	☐	_____



Number of pregnancies _____ Vaginal births ____ C-sections ____ Miscarriages ____ Terminations ____

Any problems with pregnancies, deliveries or the babies? _____

_____

_____

Last menstrual period _____ or Age at menopause_____

If still menstruating: Cycles every ____ days Days of flow ____

Light, moderate or heavy flow? _____ Clots? _____ Cramps? _____

PMS? no yes describe symptoms _____

Operations		**Injuries**	
What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all medications, vitamins, herbs and supplements which you now take regularly, prescribed or over-the-counter.

Name & dosage	**Reason**	**When started**	**Who recommended**
	2		

Allergies or intolerances to medicines:

Medication	Reaction/intolerance symptoms

Occupation, or previous occupation if retired: _____

Number of hours worked per week _____

What interests/hobbies do you have? _____

_____

_____

With whom do you live?

Name	Age	Relationship	Name	Age	Relationship

What physical activity do you do? _____

_____

What are the major stressors in your life? _____

_____

_____

What do you do to relax? (or what would you like to do?) _____

_____

_____

Religious affiliation _____

What prior experiences have you had with complementary and alternative medicine? _____

_____

Tobacco use: □ never used □smoked from age ___ to ___ . ____ packs per day.

Alcohol use: □ never used □estimated ____ drinks per week.

□ history of alcohol abuse

Recreational drugs: □ never used □ type _____

Health screening:

Have you had?	No	Yes	Date of most recent	Who ordered/performed
Mammogram				
Colonoscopy				
Pap/pelvic exam				
Bone density test				
Cholesterol screening				

Review of symptoms:

Sleep _____ **hrs/night sleep problems** _____ **do you snore? y n**

Sexual problems _____

Hair problems _____

Intolerance to heat or cold (circle if applicable)

Fatigue y n

Dry skin y n

Frequent or severe headaches y n

Weight loss y n **Weight gain** y n

Swelling y n **describe** _____

Palpitations y n

Breast pain y n

Hot flashes y n

Frequent crying or depression y n

Weakness y n

Joint pain y n

Muscle problems y n

Stomach/bowel problems y n **describe** _____

Urinary problems y n **describe** _____

NUTRITION EVALUATION

Dietary intake. Please list **all** food and drinks you have consumed in the past 24 hours. Be honest – don't write what you think we want to hear. You're only hurting yourself.

Food or drink **how prepared (baked, fried, etc)** **amount (cups, tbsp, ounces, etc)**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Any food you avoid, and why _____

_____

Was this a typical day? If not, why not? _____

Medical Appointment Cancellation Policy

Dear Patient,

Synergy Integrative Medicine strives to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, Synergy uses an appointment system that sets aside time for a patient dependent on that patient's need. When you do not show up for your appointment or notify us of your inability to keep your appointment at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to have time available for all patients, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. This also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment and does not contact us with at least a 24 hour notice, we consider this to be a missed appointment, "No Show, No Call", and the following fees will be accessed:

BHRT follow up appointments (30 minutes)	$100.00
BHRT 1 year follow up appointments (1 hour)	$175.00
Wellness follow up appointments (30 minutes)	$100.00
Wellness 1 year follow up appointments (1 hour)	$150.00

As a courtesy, we do make reminder calls for appointments. If you do not receive your message or we have incorrect information, the cancellation policy will still be in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and agree to be bound by its terms. I also understand that this notice may be changed at any time by the practice.

_____	_____
Printed Name of the Patient	**Relationship to Patient (if patient is a minor)**
_____	_____
Signature of Patient or Responsible Party	**Date**