Patient Health History Form
Benevolence Healing Arts LLC

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible, and indicate areas of confusion with a question mark. Thank you.

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ SSN: _____

Marital status: S M/P D W Height:_____ Weight:_____ Gender: M/F

Address:_____ City:_____ Zip:_____

Primary Phone:_____ Email Address:_____

Emergency Contact and Phone:_____

Occupation:_____ Employer:_____

Primary Care Physician:_____ Phone number:_____

May we contact your PCP? Y N

Are there any other health care providers you are working with? (*please list below)* If so, may we contact them? Y N

_____

_____

Where did you hear about Benevolence Healing Arts?_____

Reason For Visit

Please identify the health concerns or goals that have brought you to our clinic in order of importance below:

Condition Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you?_____

c. _____

How does this condition affect you?_____

d. _____

How does this condition affect you? _____

Please list all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking: (include dosages & frequency)

_____

_____

_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

_____

Family Medical History (Check those applicable)

Cancer	□	Mental Illness	□	Glaucoma	□
Diabetes	□	Asthma/Hay fever	□	Anemia	□
Heart Disease	□	Hives	□	Stroke	□
High Blood Pressure	□	Kidney Disease	□	Arthritis	□
Stroke	□	High Cholesterol	□	Mental Illness	□

Personal History (circle "C" for current or "P" for past)

<u>Childhood Illnesses</u>

Scarlet Fever	P	C
Diphtheria	P	C
Rheumatic Fever	P	C
Chicken Pox	P	C
Measles	P	C
Mumps	P	C
German Measles	P	C

<u>Energy and Immunity</u>

Fatigue	P	C
Slow Wound Healing	P	C
Chronic Infections	P	C
Cancer	P	C
Chronic Fatigue	P	C

<u>Head, Eye, Ear, Nose, and Throat</u>

Impaired Vision	P	C
Eye Pain/Strain	P	C
Floaters	P	C
Glaucoma	P	C
Glasses/Contacts	P	C
Tearing/Dryness	P	C
Impaired Hearing	P	C
Ear Ringing	P	C
Earaches	P	C
Headaches	P	C
Sinus Problems	P	C
Nose Bleeds	P	C
Frequent Sore Throat	P	C
Teeth Grinding	P	C
TMJ/Jaw Problems	P	C
Hay Fever	P	C

<u>Respiratory</u>

Pneumonia	P	C
Frequent Colds	P	C
Difficulty Breathing	P	C
Emphysema	P	C
Persistent Cough	P	C
Pleurisy	P	C
Shortness of Breath	P	C
Asthma	P	C
Tuberculosis	P	C

Other Respiratory Problems

_____

_____

<u>Mental/Emotional</u>

Mood Swings	P	C
Nervousness	P	C
Mental Tension	P	C
Sudden Anger	P	C
Depression	P	C
Nightmares	P	C
Addictions	P	C
Obsessive behavior	P	C

<u>Musculoskeletal</u>

Neck/Shoulder Pain	P	C
Muscle Spasms/Cramps	P	C
Arm Pain	P	C
Upper Back Pain	P	C
Mid Back Pain	P	C
Low Back Pain	P	C
Leg Pain	P	C
Joint Pain (if so, where?	P	C)

_____

_____

<u>Endocrine</u>

Hypothyroid	P	C
Hypoglycemia	P	C
Hyperthyroid	P	C
Diabetes Mellitus	P	C
Night Sweats	P	C
Feeling Hot or Cold	P	C

Cardiovascular

Heart Disease	P	C
Chest Pain	P	C
Swelling of Ankles	P	C
High Blood Pressure	P	C
Palpitations/Fluttering	P	C
Stroke	P	C
Anemia	P	C
Heart Murmurs	P	C
Rheumatic Fever	P	C
Varicose Veins	P	C

Blood Pressure_____/_____

Date taken?_____

Blood Type _____

Dermatological

Eczema	P	C
Hives	P	C
Shingles	P	C
Acne	P	C
Rosacea	P	C
Psoriasis	P	C
Warts	P	C
Rashes	P	C

Gastrointestinal

Ulcers	P	C
Changes in Appetite	P	C
Nausea/Vomiting	P	C
Epigastric Pain	P	C
Passing Gas	P	C
Heartburn	P	C
Acid Reflux/GERD	P	C
Belching	P	C
Gall Bladder Disease	P	C
Liver Disease	P	C
Hepatitis B or C	P	C
Hemorrhoids	P	C
Abdominal Pain	P	C

Genito-Urinary

Kidney Disease	P	C
Painful Urination	P	C
Frequent UTI	P	C
Frequent Urination	P	C
Heavy Flow	P	C
Urinary Dribbling	P	C
Kidney Stones	P	C
Impaired Urination	P	C
Blood in Urine	P	C
Urination at Night	P	C

Neurological

Vertigo/Dizziness	P	C
Paralysis	P	C
Numbness/Tingling	P	C
Loss of Balance	P	C
Seizures/Epilepsy	P	C
Memory Loss	P	C

Female Reproductive/Breasts

Irregular Cycles	P	C
Breast Lumps	P	C
Breast Tenderness	P	C
Heavy Flow	P	C
Clotting	P	C
Bleeding b/t Cycles	P	C
Vaginal Discharge	P	C
Premenstrual Problems	P	C
Nipple Discharge	P	C
Menopausal Symptoms	P	C
Difficulty Conceiving	P	C
Painful Periods	P	C
Low Libido	P	C
STD	P	C

Menstrual/Birthing History

Age of First Menses _____ # of Days of Menses _____ Length of Cycle _____

# of Pregnancies _____ # of Miscarriages _____ # of Abortions _____

# of Live Births _____ Birth Control Type (past and current) _____

Did you breastfeed? Y or N Are you currently breastfeeding? Y or N

Any issues with lactation? Y or N If yes, please describe _____

Do you have any reason to believe you may be pregnant? If so, how far along are you? _____

Male Reproductive

Sexual Difficulties	P	C
Low libido	P	C
Prostrate Problems	P	C
Testicular Pain/Swelling	P	C
Penile Discharge	P	C
STD	P	C

Do you experience any of these after intercourse?

Sore Low Back □ Dizziness□ Headache □

Do you have any infectious diseases? If yes, please identify: _____

Hospitalizations, Surgeries, X-Rays, CAT Scans, MRI's, Special Studies (list with dates)

_____

_____

Lifestyle

How many meals do you typically eat per day?_____ Do you crave any foods?_____

Do you follow any particular diet?(i.e. vegan, vegetarian, paleo, low carb, etc)

If yes please describe:_____

Describe your typical:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How many glasses of water do you drink per day? _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Hours/Week at work _____ Do you enjoy work? Y N

Why/Why not? _____

Nicotine/Alcohol/Caffeine Use _____

Have you experienced any major physical or emotional traumas? Y N

Please explain_____

_____

Is there anything else we should know? _____

_____

_____

Financial Policy

Unless prior arrangement is made, full payment is due at the time of service. Payment may be made by cash, personal check, or credit card. For patients paying **in full** at the time of services, there is a 20% discount on all services. This does not apply to supplements, insurance co-pays or deductibles.

For your convenience, we will bill your insurance provider. We will contact your insurance company for verification of benefits. However, insurance companies may reimburse differently than the information they initially provide to us. You are responsible for and will be billed for any resulting unpaid balance. If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service. You are expected to pay your deductible if it is still due, your co-payment, for any non-covered services, and for all supplements and products at the time of service.

Please provide us with notice of cancellation at least 24 hours in advance of your scheduled appointment. If cancellation notice is less than 24 hours, or you fail to come for a scheduled appointment, there will be a $50.00 fee.

Accounts greater than 30 days past due will be charge a $10 administrative fee. Accounts greater than 90 days overdue will be sent to a collections agency, unless you are making timely payments on an approved payment plan. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service. There will be a $35.00 fee for a returned check.

Financial Agreement:

- I have read the policies above and understand them.
- I understand that I will be provided a copy of this policy at my request.
- I agree to promptly pay all fees and charges for treatment provided to me and/or my family.
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- Should legal action be taken by this office to collect an unpaid balance due for services provided, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

These policies are subject to change without notice.

I have read, understood and agree to the policies described above:

Signature:_____ Date:_____

For Insurance Patients Only

Auto/Worker's Comp Insurance

In condition due to accident? Auto Work Accident date: _____

Claim filed? Y N

Claim # _____

Insurance company: _____

Insurance

Insurance company: _____

Policy Holder: _____

Relationship to patient: _____

Insurance ID# _____

Group Plan # _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company. I assign all insurance benefits, if any, otherwise payable to me for services rendered, directly to my practitioner at Benevolence Healing Arts LLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature:_____ Date _____

Acknowledgement of Receipt of Privacy Policy

Your signature below acknowledges that you have received Notice of our Privacy Practices.

Signature:_____ Date:_____