

Integrative Medicine of Scottsdale, PLLC
Patient Intake Sheet

Patient information

Name:	Today's Date:	
Street:	Home Phone: ()	
City:	Work Phone:()	Cell Phone:()
State:	Date of Birth:	Age:
Zip:	Weight:	Height:
Employer:	Who referred you?	
Your Occupation:	Who is your primary care doctor?	

What is the medical reason you are seeing the doctor?

Medications: Allergies:

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Past surgical history (please list all surgeries and dates):

Review of medical history (please mark all appropriate boxes):

General

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low sex drive |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Alcohol (Quantify _____) | <input type="checkbox"/> Weakness | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Tremors | <input type="checkbox"/> Other: |

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|---|---|
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Earaches | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Other: |

Cardiovascular

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Swelling in feet | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> MVP | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Murmur | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other: _____ |

Respiratory

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Valley Fever | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Smoking (packs/day____) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Other: _____ |

Gastrointestinal

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Abd. cramps | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> GI bleeding from medications | <input type="checkbox"/> Other: _____ |

Musculoskeletal

- | | | |
|---|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Tennis elbow |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Bursitis |
| | <input type="checkbox"/> Joint injury | <input type="checkbox"/> Other: _____ |

Renal

- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Kidney problems |
| | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Other: _____ |

Hepatic

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Hepatitis (Active? _____) | <input type="checkbox"/> Other: _____ |
|---|---------------------------------------|

Neuropsychological

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stress problems | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Other: _____ |

Patient Name/DOB:

Family medical history:

Which family member(s)?

- Headaches _____
- Heart disease _____
- Stroke _____
- Diabetes _____
- High blood pressure _____
- Increased cholesterol _____
- Arthritis _____
- Rheumatoid arthritis _____
- Kidney problems _____
- Liver problems _____
- Seizures _____
- Osteoporosis _____
- Cancer _____
- Other medical problems: _____

Financial Agreement:

I understand and agree that I am financially responsible for all charges and payment must be made at the time of visit. I understand and agree that I will pay a fee of \$89.00 for the doctor's time if I fail to cancel or reschedule an appointment without 24 hours notice.

Patient's Signature _____ Date _____

Patient Name/DOB:

Authorizations and Releases

NAME _____ **DOB** _____

Consent for Treatment

I, the undersigned, hereby authorize Dr _____ and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, and to administer treatment as necessary.

I, also certify that no guarantee or assurance has been made to the results that may be obtained.

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT AT TIME OF SERVICES.

Patient's Signature _____ **Date** _____ **Witness** _____

X-Ray/Medical Records Release

I have requested the release of records of (patient's name) _____ which are a part of the records at (facility) _____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: Integrative Medicine of Scottsdale, PLLC. 14301 N. 87th Street Suite 100 Scottsdale, AZ 85260 or fax records to 480-314-0628

Patient's Signature _____ **Date** _____ **Witness** _____

DOB: _____ **SSN:** _____

Consent for Treatment of Minor

I hereby authorize _____ N.M.D. and whomever he/she may designate as his/her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship of child) _____ (child's name) _____

Guardian's Signature _____ **Date** _____ **Witness** _____

Integrative Medicine of Scottsdale, PLLC

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Scottsdale, AZ 85260

Telephone 480-219-2351

Fax 480-314-0628

Insurance Tips

We do not take insurance, and require our patients to pay in full for the appointment at the time of your visit. We will give you an itemized bill that you can submit to your insurance company and request reimbursement. Keep in mind, all insurance policies are different and it is entirely up to your insurance company whether they reimburse you for any expenses. We will try and assist in any way we can.

Below are some things that may assist you when seeking reimbursement from your insurance carrier.

1. Contact your insurance company and ask them what they need in order for you to get reimbursed for services you have paid for.
2. The receipt that you are given has the CPT codes on it (this is the code that tells the insurance company what was done.) This receipt also has the ICD9/diagnosis codes (this tells the insurance why it was done.)
3. If additional information is need in order for you to get reimbursed from your insurance company, please let us know and remember we will assist in any way we can.
4. Feel free to contact us with any questions that we may be able to answer.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____