OM Integrative Infusion Center

Patient Demographic Form

Today's Date ______________

Patient Information

Patient Name: ____ Date of Birth(DOB): ___/___/_____Age: ____
Social Security Number: _______/________/________ Sex: M F
Marital Status: Single Married Widow/er Divorced Partner
Mailing Adress: ____
Street with house number City State Zip code
Physical address (if not the same as paling address): ____
Street City State Zip code
Home Phone: (_____) ______- ________ Cell/pager (____)______-________ May we leave a message? Y N
May we contact you via email? Y N Email Address: ____
Patient Employer: ______________________________ Occupation: __________________________ Full/part time
Address: ____ Work phone (_____)______- _________

Emergency Contact: ____________________________ DOB ___/___/______ Work #: (___)____- _________
Address: _____________________________________ Social Security #: _______-________-__________

Guarantor/Parent Information (if applicable)
Responsible Party Name: _________________________________ DOB: ____/____/_____ SS#______________
Address: ____ Home phone: (_____) ______-__________
Employer: ____ Work phone: (_____) ______- _________
Relationship to patient: ____________________________________Cell/Pager #: (______) ______- _________

Patient Referral Information
Referred by (circle or complete) Family, Friend, Hospital, Health care provider ________________________
Primary Care Provider __________________________________ Referring Provider _______________________

PLEASE read and sign
I understand that I am responsible for all charges incurred on my behalf. All services at this center are not covered by all types of Insurance and are to be paid on the date of services rendered.

Patient/responsible party: ____ Date ____________________

Health History

Name____ Today's Date ____________________

Age ____ Height _____ Weight ______ gain or loss in the last year ____ Gender M F # of children _____

Allergies ____

Reason for the clinic visit: ____

____ Date this began ________________

Date of last physical Exam ___________ Practitioner name and phone # ___________________________

Laboratory performed (Ex. Stool analysis, blood, urine, chemistries, hair) ____________________________

____

Outcome ____

What types of therapy have you tried for this problem(s): Underline all that apply: Diet modification Fasting Vitamins/minerals Herbs Homeopathy Chiropractic Acupuncture Conventional medications

Other____

List current health problems for which you are being treated: ______________________________________

____

Current medications (prescription or over-the counter): ____

____

Major hospitalizations, surgeries, injuries: Please list all procedures, complications, and dates:

Year	Surgery, illness, injury	Outcome
________	____	____________________
________	____	____________________
________	____	____________________

Rate the level of stress that you are experiencing on a scale of 1 (lowest) to 10 (highest) ________________

Identify what is your major cause of stress: (job change, work, home, finances, legal issues _____________

Is your job associated with potentially harmful chemicals (ex. pesticides, radioactivity, solvents) or health/life threatening activities (fireman, farmer, miner). Explain ____

Do you have: Corrective lenses _______ Dentures _______ Hearing Aides ______ other implanted medical devices ____

Recent changes in your ability to: See, hear, taste, smell, feel hot/cold sensations, move around as you had before. Please explain ____

Strong desire for any of the following flavors: sour, bitter, sweet, rich/fatty, spicy/pungent, salty ___________

Strong dislike for any of the following flavors: sour, bitter, sweet, rich/fatty, spicy/pungent, salty ___________

Do you: __prefer warmth (Ex. Food, drinks, weather, etc.) __ Prefer cold (Ex. Food, drinks, weather, etc.

Is your sleep disturbed at the time each night? __________ If yes, what time? ___________

Time of day you feel the least symptoms:

__ 7-9AM __9-11AM __ 11AM - __ 1-3 PM

__ 3-5 PM __ 5-7 PM __ 7-9 PM __ 9-11 PM

__ 11 PM - 1 AM __1-3 AM __ 3-5 AM __ 5-7 AM

Time of day you feel the worst symptoms:

__ 7-9AM __9-11AM __ 11AM - 1PM __ 1-3 PM

__ 3-5 PM __ 5-7PM 7-9 PM __ 9-11PM

__ 11 PM - 1 AM __1-3 AM __ 3-5 AM __ 5-7 AM

Do you experience any of these general symptoms EVERY DAY?

__ Debilitating fatigue
__ Constipation
__ Panic Attacks
__ Fecal Incontinence
__ Vomiting
__ No interest in eating
__ Itching/rash

__ Shortness of breath
__ Chronic pain/inflammation
__ Nausea
__ No interest in sex
__ Discharge
__ Dizziness
__ Low grade fever

__Insomnia
__ Depression
__ Bleeding
__ Headaches
__ Urinary Incontinence
__ Diarrhea

Stool Frequency: # of Stools/per day _______

Other ____

MEDICAL HISTORY (x all that apply)

__ Arthritis
__ Alcoholism
__ Bronchitis
__Carpal Tunnel
__ Colitis
__ Diabetes
__ Eating Disorder
__ Eyes, ears, nose, throat issues
__ Food Intolerance
__ Glaucoma
__ Chronic Infection
__ Kidney or Bladder Disease
__ Mental Illness
__ Neurologic problems(Parkinsons)
__ Thyroid problems
__ Pneumonia
__ Skin problems
__ Urinary Tract Infection
__ Allergy/Hay Fever
__ Autoimmune Disease
__ Cancer
__ High Cholesterol
__ Dental Problems
__ Diverticular Disease
__ Epilepsy
__ Environmentally sensitive
__ Gastroesophageal Reflux Disease
__ Gout
__ Inflammatory Bowel Disease
__ Learning Disabilities
__ Intellectual Disability
__ Sinus Problems
__Obesity
__ Sexually Transmitted Disease
__ Tuberculosis
__ Varicose Veins
__ Asthma
__ Blood pressure problems
__ Chronic Fatigue
__ Circulatory issues
__ Depression
__ Drug Addiction
__ Emphysema
__ Fibromyalgia
__ Genetic Disorder
__ Heart Disease
__ Irritable Bowel Syndrome
__ Liver/gall bladder Disease
__ Migraine headaches
__ Stroke
__ Osteoporosis
__ Seasonal Affective
__ Ulcer
__ Open wounds
__ Other ____

Male Concerns (x all that apply)

__ Prostate Problems (BPH, etc.)
__ Infertility
__ Prostate Cancer
__ Sexually Transmitted Disease
__ Decreased Sex Drive
__ Other _________________

Female Concerns (x all that apply)

— Menstraul Irregularities
__ Fibrocystic Breast Disease
__ Breast Cancer
__Decreased Sex Drive
__Endometriosis
__ Fibroid/Ovarian Cysts
__ Pelvic Inflammatory Disease
__ Sexually Transmitted Diease
__ Infertility
__ Premenstrual Syndrome
__ Vaginal Infections
__ Other _________________

Age of first period ________
Date of last gynecological exam ________
Mammogram +___ - ___
PAP + ___ - ___
Form of birth control _________________
___ # of children
___ # of pregnancies
___ births by C-section
___Surgical Menopause
Date of last menstrual cycle _______
Length of cycle ____ days
# of days between cycles __
Any recent changes in normal menstrual flow (Ex. Heavier, large clots, scanty) ___________________________
____

Family Health History (Parents and Siblings) x all that apply

__ Arthritis
__ Alzheimer's Disease
__ Diabetes
__ Genetic Disorder
__ Infertility
__ Intellectual Disability
__ Obesity
__ Stoke
__ Asthma
__ Cancer
__ Drug Addiction
__ Glaucoma
__ Learning Disabilities
__ Migraine Headaches
__ Osteoporosis
__ Suicide
__ Alcoholism
__ Depression
__ Eating Disorder
__ Heart Disease
__ Mental Illness
__ Neurologic Disorders (Parkinson's, Paralysis)
__ Other ____
____

Health Habits

__ Tobacco Cigarettes/day # _______ Cigars #/day ______
__ What type of water: tap ____filtered _____ Other___________________________ # oz./day_________
__ Alcohol Wine # of glasses/day or week _______ Beers #/ day or week ____ Liquor oz./day or week ____
__ Caffeine Coffee, # cups/day ____ Tea, # cups/day ___ Soda w/ caffeine, # oz./day ____ Other _______

Exercise (x all that apply)

__ 5-7 days/week
__ 3-4 days/week
__ 1-2 days/week
__ 45 minutes or more duration per workout
__ 30-45 minutes duration per workout
__ Less than 30 minutes
__ Walk
__ Run, jog, jump rope
__ Weight lift
__ Swim
__ Box
__ Yoga
__ Cross Train

Nutrition, Diet and Food Frequency (x all that apply)

__ Mixed food diet (Animal and Vegetable sources)
__ Vegetarian
__ Vegan
__ Salt Restriction_
__ Fat Restriction
__ Reduce Starch/ Carbohydrates
__ The Zone Diet
__ Restrict Total Calories

Check (x) Specific Food Restrictions: __ Dairy __ Wheat __ Eggs __ Soy __ Corn __ All Gluten. Other ____

Servings per Day:
Fruits (citrus, melons, etc.) ______
Grains (unprocessed) ______
Dark greens or deep yellow/orange vegetables ______
Beans, Peas, Legumes ______
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

__ Skip breakfast
__ Two meals/day
__ One meal/day
__ Graze
__ Food Rotation
__ Add salt to food
__ Eat constantly whether hungry or not
__ Eat on the run

Current Supplements (x all that apply)

__ Multivitamin/Minerals
__ Vitamin C
__ Vitamin E
__ EPA/DHA
__ Evening Primrose/GLA
__ Calcium, source _______
__ Magnesium
__ Zinc
__ Probiotics ____________
__ Minerals (list) _____________________
__ Digestive Enzymes
__ Amino Acids
__ CoQ10
__ Antioxidants _______________
__ Herbs - teas
__ Chinese Herbs
__ Ayurevedic herbs
__ Homeopathy
__ Bach Flowers
__ Protein shakes _____________
__ Liquid Meals
__ Superfoods (Ex. bee pollen, phytonutrient blends, etc.) ____
__ Other ____

What would you hope to achieve: (x all that apply)

__ Have more energy
__ Be stronger
__ More endurance
__ Increase sex drive
__ Be thinner
__ Be more muscular
__ Improve complexion
__ Stronger nails
__ Healthier hair
__ Be less moody
__ Be less depressed
__ Be less indecisive
__ Feel more motivated
__ Be more organized
__ Improve memory
__ Be able to think more clearly/focused
__ Be able to test better
__ Be free of pain
__ Stop use of over-the-counter medications
__ Sleep better
__ Have agreeable breath
__ Have agreeable body odor
__ Have stronger teeth
__ Get less colds/flu
__ Get rid of allergies
__ Reduce risk of inherited disease, List ____________________

Name three things in this life that are most important to you:

1. ____
2. ____
3. ____

Thank you for your time. We look forward to partnering with you in your quest for wellness.

Cancellation and No Show Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have found it necessary to implement a cancellation and no show policy. This policy enables us to better utilize our available appointments, facilities and clinical resources to serve those patients in need of care and our services.

Cancellation of Appointment

If it is necessary to cancel your appointment, we require that you call in and contact us 24 hours prior to your scheduled appointment. Appointments are in high demand and your early cancellation will give another person the opportunity to have access to our care.

How to Cancel Your Appointment

To cancel an appointment, please call 712.722.0786 during normal business hours, or leave a message if after hours. **Cancellations by contacting anyone in the office personally, by written email or voicemail, will not be honored.** Regular business hours for OM Integrative Infusion Center, are presently every Monday, Wednesday and Friday, unless closed in observance of a holiday.

Late Cancellations

Late cancellations will be considered a "no show" appointment, unless emergent, extenuating and verifiable circumstances exist.

No Show Policy

A "no show" appointment is when someone misses an appointment without cancelling the appointment 24 hours prior to their scheduled appointment, as disclosed above. Failure to be present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". In addition, there will be a $50 fee/per "no show" appointment applied to the patient's file. Repeated "no show" appointments could result in discharge from our practice.

I have read and understand the above Cancellation and No Show Policy.

____ ________________________
Patient Name Date

____
Patient Signature