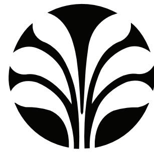


Health Center of Integrated Therapies
A Service of Longmont United Hospital

1551 Professional Lane, Suite 125 Longmont, CO 80501
Phone (303)651-5188 Fax (720) 494-4741

HEALTH HISTORY FORM

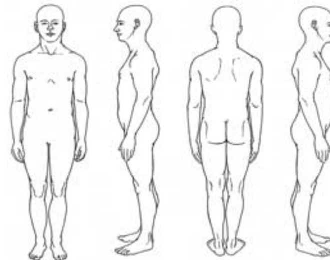
My appointment today is to receive the following service (check one):
☐ acupuncture ☐ manual lymph drainage ☐ massage therapy ☐ nutritional/herbal consultation
Is this your first experience receiving this service? ☐ Yes ☐ No

Your Name ____ **Today's Date** _____/_____/_____
Address ____ **Date of Birth** _____/_____/_____
City ________________________ **State** _______ **Zip** _________ **Sex** ☐ M ☐ F
Home Phone ____________________________
Work Phone _____________________________ **Occupation** ___________________________________
Primary Language ☐ English ☐ Spanish ☐ Other __________________________
How do you learn best? ☐ by discussion ☐ by visual aid ☐ by doing/hands-on
Emergency Contact ______________________ **Relation to you** ______________ **Phone** ___________________
Whom may we thank for referring you? ____

How would you rate your overall health? ☐ poor ☐ fair ☐ good ☐ very good ☐ excellent
Are you on a special diet? ☐ Yes ☐ No **If yes, please describe.** ____
Are you in pain? ☐ Yes ☐ No
If yes, mark your current pain level with an "X" on a scale of 0-10.

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain				Severe Pain	

If yes, mark the location(s)of the pain with an "X"



What are your goals for your treatment today? ____
Your Primary Healthcare Physician's Name ____
Address, City, State, Zip and Phone ____
Please list other practitioners whom you receive treatment from. _______________________________________
____

Women only: Are you pregnant? ☐ Yes ____ weeks ☐ No **Are you currently breastfeeding?** ☐ Yes ☐ No
Number of pregnancies _____ **Age(s) of child(ren)** ____
If you have any complications or high-risk conditions in this or a previous pregnancy, please describe.
____

Please list any injuries (falls, sprains, strains, bone fractures, dislocations, etc.) and surgeries with date(s) of each. ____
____
Do you have any special needs and/or concerns with mobility and function? ☐ Yes ☐ No
If yes, please describe. ____

Please mark other conditions that you currently have with a "C" and those that you have had previously with a "P."

General
___ Depression
___ Difficult sleep
___ Dizziness
___ Forgetfulness
___ Nervousness
___ Numbness
___ Seizures
___ Sweats
___ Tiredness
___ Weight gain
___ Weight loss

Cardiovascular
___ Anemia
___ Heart disease
___ High blood pressure
___ Low blood pressure
___ Pacemaker
___ Poor circulation
___ Swelling of ankles
___ Stroke
___ Varicose veins

Eyes, Ears, Nose & Throat
___ Allergy
___ Loss of hearing
___ Nosebleeds
___ Ringing in ears
___ Sinus problems
___ Vision changes

Gastrointestinal
___ Bloating
___ Bowel changes
___ Celiac Disease
___ Constipation
___ Crohn's Disease
___ Diarrhea
___ Gas
___ Nausea

Metabolic
___ Diabetes
___ Kidney disease
___ Liver disease
___ Thyroid problems

Musculoskeletal
___ Arthritis
___ Bursitis
___ Fibromyalgia
___ Hernia
___ Herniated disk
___ Inflammation
___ Multiple sclerosis
___ Osteoporosis
___ Prosthesis
___ Rheumatoid arthritis

Pulmonary
___ Asthma
___ Shortness of breath

Urogenital
___ Irregular menses
___ Painful menses
___ Painful ovulation
___ Vaginal infections
___ Miscarriage
___ Prostate problems

Skin
___ Bruise easily
___ Rash
___ Scars

Infectious Disease
___ AIDS/HIV
___ Cancer
___ Chicken pox/shingles
___ Hepatitis
___ Measles
___ Mononucleosis
___ Mumps
___ Pertusis
___ Polio
___ Rheumatic fever
___ Scarlet fever
___ Sexually transmitted disease
___ Tuberculosis

Health Risk Reduction
___ Use tobacco products
___ Use caffeine
___ Use alcohol
___ Use illicit drugs

What medications are you currently taking? For what conditions and/or reasons? Please include prescriptions, over the counter medications, homeopathic remedies, herbs and vitamins.

____

____

Do you have any allergies or sensitivities to lotions, oils , moxa or aromatherapy products? ☐ Yes ☐ No
If yes, please describe. ____

Do you feel safe at home? ☐ Yes ☐ No If no, please describe.________________________________

Gratuity & Tipping Policy: Our Code of Business Conduct does not allow employees to accept gratuities or tips from patients. If you wish to thank your practitioners, we suggest completing a comment card to recognize their outstanding service and/or making a donation on their behalf to the Health Center of Integrated Therapies. Your generous donations provide integrated therapy scholarships to underserved community members and helps Longmont United Hospital provide integrated therapy services. A receipt will be given for your income taxes.

Cancellation Policy: Honoring time commitments allows us to provide you, and all our patients, with the best professional care and service. If you need to cancel your appointment, we require 24-hour notice prior to your scheduled appointment. If you do not cancel your appointment before 24 hours of your appointment, or do not come to the appointment, you will be charged the full appointment fee. Please call as soon as you know that you are unable to keep your appointment.

Patient Identifier: To be in compliance with Joint Commission standards, we must have two patient identifiers – your photo (driver's license, passport or other photo ID) and your date of birth – in your confidential patient file. Thank you for providing your photo and your date of birth for your records.

By signing below, I understand the above mentioned policies, and I hereby give my consent for assessment, treatment and recommendations considered necessary by the practitioner designated by the Health Center of Integrated Therapies. I hereby authorize release of information from this assessment, treatment and recommendations to my physician and other complementary practitioners as indicated.

Patient Signature ______________________________ **Date** ________________

Practitioner Signature ___________________________ **Date** ________________

We are required to ask about Advanced Directives, Living Will, Medical Power of Attorney, Five Wishes.
Do you have a physician-signed Colorado Do Not Resuscitate Order? ☐ Yes ☐ No
If yes, would you please provide us with a copy for our records? ☐ Yes ☐ No
If no, do you want information about Advanced Directives? ☐ Yes ☐ No
Information given ________ Staff Initials