Date_____ **IDEAL HEALTH CENTER**

Name: _____ Preferred name: _____

Address: _____

City/State/Zip: _____

Phone #s (cell)_____ (work) _____

Email address: _____

Birthday_____Age _____

Occupation_____Employer _____

Marital status ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Emergency contact: Name _____

Relationship_____Phone # _____

Who may we thank for referring you? _____

Financial Responsibility

Who is responsible for the payment? _____ How will you pay for your care? ◯ credit/debit card ◯ cash ◯ insurance

Health History

Are you receiving care from other health care professionals? ◯ Yes ◯ No

If yes, please name them and their specialty

_____

_____

Please list any drugs or medications you are taking _____

_____

Please list any vitamins/herbs/homeopathies/other you are taking _____

_____

Are you pregnant? ◯ Yes ◯ No If yes, what month? _____

What are your current health concerns? _____

_____

_____

Do you have, or have you had, any of the following (Please check all that apply) ?

◯ pneumonia	◯ mumps	◯ influenza	◯ rheumatic fever	◯ smallpox
◯ pleurisy	◯ polio	◯ chickenpox	◯ thyroid disease	◯ diabetes
◯ epilepsy	◯ cancer	◯ depression	◯ whooping cough	◯ anemia
◯ eczema	◯ measles	◯ arthritis	◯ heart disease	◯ rashes
◯ colitis	◯ stroke	◯ allergies _____		

If you ever been diagnosed with another disease or condition, please describe _____

_____ _____

Do you drink	◯ coffee	◯ tea	◯ alcohol
Do you use	◯ cigarettes	◯ recreational drugs	◯ artificial sweeteners

Are you currently suffering from (please check all that apply)

◯ neck pain	◯ difficulty breathing	◯ discolored urine
◯ low back pain	◯ stuffy nose	◯ gas/bloating after meals
◯ headache	◯ fainting	◯ heartburn
◯ migraines	◯ weight loss	◯ irritable bowel
◯ arm pain/tingling	◯ poor appetite	◯ black or bloody stools
◯ shoulder pain	◯ excessive appetite	◯ constipation
◯ hand pain/tingling	◯ nervousness	◯ hemorrhoids
◯ leg pain/tingling	◯ confusion	◯ liver problems
◯ jaw pain	◯ depression	◯ paralysis
◯ chest pain	◯ dental problem	◯ numbness
◯ lung problems	◯ excessive thirst	◯ fatigue
◯ heart problems	◯ frequent nausea	◯ dizziness
◯ abnormal blood pressure	◯ prostate problem	◯ loss of sleep
◯ irregular heartbeat	◯ breast pain/lump	◯ difficulty hearing
◯ ankle swelling	◯ cramps	◯ ear pain
◯ cold extremities	◯ painful urination	◯ other_____
◯ blurred vision	◯ bladder trouble	_____
◯ vision problems	◯ excessive urination	_____

The above is accurate to the best of my knowledge.

Ideal Health Medical Center is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.
Please call us at 404.348.4441 by 3:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 p.m. on Friday. If prior notification is not given, you will be charged $25 for the missed appointment.
Fees must be paid before patients can be seen.
Please sign below to consent to these terms.

_____ _____

(signature) (date)