Integrative Health Care

Dr. Lisa Rhodes D.P.M., L.Ac.
Executive Center
5055 Swamp Rd., Suite 203
Fountainville, PA 18923215-230-4600
Fax 215-230-8404
www.Integrative HealthCarePA.com

Dear Patient,

Many of the patients at IHC are being seen for environmental illness, chemical sensitivity, or food allergies. It is extremely important that care be taken to maintain the office in a manner that will promote healing and reduce the toxic exposure for those concerned. In light of this, the following policies and procedures have been developed. Please read them carefully and sign below, indicating your understanding and willingness to comply.

- Please DO NOT wear perfume, cologne, scented hair spray, strongly scented deodorant, or lotions, on the day of your appointment. This applies even if you have an appointment in the evening because the scents and chemicals contained in these products can be toxic to others or yourself, and they can linger on the skin and clothing.

- Please DO NOT bring food or drink (such as coffee) into the waiting room.

- In order to receive the full benefit of your therapy , it is important to adhere to the protocol you and your practitioner have agreed upon. If you miss a scheduled appointment please reschedule for the same week . If this is not possible, your appointment may be made up at a later time.

- There is often a waiting list for appointment times at IHC. Therefore, 48 hour notice must be given for cancellations. Please give us correct notice or a charge for your appointment will be applied to your credit card.

- Payment is REQUIRED at the time of your appointment unless other arrangements have been made.

Thank You.

Signature:_____ Date:_____

INTAKE

Name:_____ Date:_____

Address:_____

City:_____ St:_____ Zip:_____

Telephone: (C)_____ ____(H)_____ (W/F)_____

DOB:____/____/_ ____SSN:_____ Occupation:_____

Physician:_____ Telephone:_____

Sex: M:___ F:___ Referred by:_____

E-mail:_____

Chief Complaint:_____

_____

_____

_____

_____

_____

_____

Have you ever received: Acupuncture?_____ NAET?_____ NMT?_____ NET?_____
If so, please describe your experience and/or results:_____
_____

Please continue on back if more space is needed.

Name: _____ Date: _____

Date of last physical: _____ Physician: _____

Results: _____

_____

HABITS:

	Heavy	Moderate	Light	None	Comments
Alcohol:	[ ]	[ ]	[ ]	[ ]	_____
Drug Abuse	[ ]	[ ]	[ ]	[ ]	_____
Coffee	[ ]	[ ]	[ ]	[ ]	_____
Tea	[ ]	[ ]	[ ]	[ ]	_____
Soda	[ ]	[ ]	[ ]	[ ]	_____
Natural Juice	[ ]	[ ]	[ ]	[ ]	_____
Juice Drink	[ ]	[ ]	[ ]	[ ]	_____
Tobacco	[ ]	[ ]	[ ]	[ ]	_____
Salt	[ ]	[ ]	[ ]	[ ]	_____
Sugar	[ ]	[ ]	[ ]	[ ]	_____
Medications	[ ]	[ ]	[ ]	[ ]	_____
Food Intake	[ ]	[ ]	[ ]	[ ]	_____
Water	[ ]	[ ]	[ ]	[ ]	_____

	Bottles	Tap	Filtered	Distilled	
	[ ]	[ ]	[ ]	[ ]	_____

	Good	Fair	Poor	
Exercise	[ ]	[ ]	[ ]	_____
Sleep	[ ]	[ ]	[ ]	_____
Appetite	[ ]	[ ]	[ ]	_____
Stress	[ ]	[ ]	[ ]	_____
Energy	[ ]	[ ]	[ ]	_____

Choose one or two emotions that seem predominant in your life (e.g. frequently experienced, difficult to express, or in some way influential): _____

_____

_____

_____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic/significant experience you have had (e.g. divorce, change of job, death in family, bankruptcy, change of residence, etc.):

Date:	Event:

Preferences:	Most liked	Least liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

How old is your home?_____ How long have you lived there?_____
Do you live in the woods?_____ Near water?_____ Near high tension wires?_____
Do you live in the country?_____ In a town hose or city?_____ Near high traffic area?_____
How many hours a day do you spend in a car/bus/train?_____ Do you live near a chemical plant?_____

Please indicate the foods you most commonly eat

_____
_____
_____
_____
_____

Symptom Review

Instructions: Please indicate the frequency that you experience by **circling** the following symptoms; **1** for never, **2** for rarely, **3** for sometimes, **4** for often, and **5** for constant. **Every Symptom needs to have a number circled.** When appropriate, add date (e.g. heart attack '98; pregnancy '75, '80).

GENERAL

1 2 3 4 5 Fatigue
1 2 3 4 5 Fever
1 2 3 4 5 Depression
1 2 3 4 5 Anxiety
1 2 3 4 5 Agitation
1 2 3 4 5 Weight loss
1 2 3 4 5 Weight gain
1 2 3 4 5 Fainting
1 2 3 4 5 Anemia
1 2 3 4 5 Headaches'
1 2 3 4 5 Dizziness
1 2 3 4 5 Memory loss
1 2 3 4 5 Forgetfulness
1 2 3 4 5 Confusion
1 2 3 4 5 Eating disorder
1 2 3 4 5 Low energy level
1 2 3 4 5 High energy level
1 2 3 4 5 Compulsive behavior
1 2 3 4 5 Tourette' s Syndrome
1 2 3 4 5 Phobias
1 2 3 4 5 Addiction
1 2 3 4 5 Other _____

EYES EARS NOSE THROAT

1 2 3 4 5 Failing vision
1 2 3 4 5 Metallic taste
1 2 3 4 5 Inflammation
1 2 3 4 5 Eye strain
1 2 3 4 5 Blurred vision
1 2 3 4 5 Eyelid problem
1 2 3 4 5 Excessive blin1ing
1 2 3 4 5 Pain
1 2 3 4 5 Glaucoma
1 2 3 4 5 Hearing loss
1 2 3 4 5 Sensitivity to noise
1 2 3 4 5 Earaches
1 2 3 4 5 Discharge
1 2 3 4 5 Ringing
1 2 3 4 5 Loss of smell
1 2 3 4 5 Nasal drainage
1 2 3 4 5 Frequent colds
1 2 3 4 5 Sinus trouble
1 2 3 4 5 Congestion
1 2 3 4 5 Bleeding
1 2 3 4 5 Gum problems
1 2 3 4 5 Teeth problems
1 2 3 4 5 Tongue problems
1 2 3 4 5 Lip problems
1 2 3 4 5 Jaw problems
1 2 3 4 5 Unusual tastes
1 2 3 4 5 Difficulty in swallowing
1 2 3 4 5 Loss of taste
1 2 3 4 5 Enlarged thyroid
1 2 3 4 5 Enlarged glands
1 2 3 4 5 Sore throat
1 2 3 4 5 Hoarseness
1 2 3 4 5 Difficulty in swallowing
1 2 3 4 5 Other _____

RESPIRATION

1 2 34 5 Asthma
1 2 34 5 Wheezing
1 2 34 5 Pain
1 2 3 4 5 Cough
1 2 3 4 5 Phlegm
1 2 3 4 5 Other _____

CARDIOVASCULAR

1 2 3 4 5 Palpitations
1 2 3 4 5 High blood pressure
1 2 3 4 5 Tightness in chest
1 2 3 4 5 Low blood pressure
1 2 3 4 5 Difficulty lying flat
1 2 3 4 5 Stroke
1 2 3 4 5 Heart attack
1 2 3 4 5 Varicose veins
1 2 3 4 5 Irregular heart
1 2 3 4 5 Hardening of the
1 2 3 4 5 Bruise easily
1 2 3 4 5 Bleed easily
1 2 3 4 5 Cold limbs
1 2 3 4 5 Other _____

GASTROINTESTINAL

1 2 3 4 5 Thirst
1 2 3 4 5 Irregular appetite
1 2 3 4 5 Acid food upset
1 2 3 4 5 Digestive pain
1 2 3 4 5 Nausea
1 2 3 4 5 Diarrhea
1 2 3 4 5 Constipation
1 2 3 4 5 Hemorrhoids
1 2 3 4 5 Colon problems
1 2 3 4 5 Gas
1 2 3 4 5 Vomiting
1 2 3 4 5 Vomiting blood
1 2 3 4 5 Black stool
1 2 3 4 5 Blood in stool
1 2 3 4 5 Intestinal parasites
1 2 3 4 5 Liver problems
1 2 3 4 5 Jaundice
1 2 3 4 5 Gall Bladder problems
1 2 3 4 5 Irritable bowel
1 2 3 4 5 Other _____

MUSCLE AND JOINT

1 2 3 4 5 Stiff neck
1 2 3 4 5 Backache
1 2 3 4 5 Painful tail bone
1 2 3 4 5 Foot pain

1 2 3 4 5 Hernia
1 2 3 4 5 Spinal curvature
1 2 3 4 5 Swollen joints
1 2 3 4 5 Stiff joints
1 2 3 4 5 Arthritis
1 2 3 4 5 Sore muscles
1 2 3 4 5 Muscle weakness
1 2 3 4 5 Sciatica
1 2 3 4 5 Difficulty walking
1 2 3 4 5 Foot problems
1 2 3 4 5 Other _____

URINATION
1 2 3 4 5 Frequent
1 2 3 4 5 Difficult
1 2 3 4 5 Painful
1 2 3 4 5 Nighttime
1 2 3 4 5 Bleeding
1 2 3 4 5 Bed wetting
1 2 3 4 5 Inability to control urination
1 2 3 4 5 Urine with foul odor
1 2 3 4 5 Discolored urine
1 2 3 4 5 Other _____

SKIN
1 2 3 4 5Eruptions
1 2 3 4 5 Acne
1 2 3 4 5 Dry skin
1 2 3 4 5 Clammy skin
1 2 3 4 5 Rashes
1 2 3 4 5 Dryness
1 2 3 4 5 Moles or lumps that change
1 2 3 4 5 Sweating
1 2 3 4 5 Night sweat
1 2 3 4 5 White spots under nails
1 2 3 4 5 Other _____

Neurological
1 2 3 4 5 Nervousness
1 2 3 4 5 Tremors
1 2 3 4 5 Convulsions
1 2 3 4 5 Numb or tingling in limbs
1 2 3 4 5 Poor coordination
1 2 3 4 5 Nerve pain/neuralgia
1 2 3 4 5 Restless leg
1 2 3 4 5 Other____

FEMALE
1 2 3 4 5 Painful menstrual periods
1 2 3 4 5 Early menses
1 2 3 4 5 Delayed menses
1 2 3 4 5 Abnormal bleeding
1 2 3 4 5 Menopause
1 2 3 4 5 Hot flashes
1 2 3 4 5 Night sweats
1 2 3 4 5 Irregular menstrual cycle
1 2 3 4 5 Miscarriage
1 2 3 4 5 Vaginal discharge
1 2 3 4 5 Vaginal pain
1 2 3 4 5 painful intercourse
1 2 3 4 5 Breast pain
1 2 3 4 5 Lumps in breast
1 2 3 4 5 Breast discharge
1 2 3 4 5 Reduced sexual energy
1 2 3 4 5 Pregnancy
1 2 3 4 5 Complications in pregnancy
1 2 3 4 5 Yeast infections
1 2 3 4 5 Ovarian cysts
1 2 3 4 5 Other _____

MALE
1 2 3 4 5 Prostate problems
1 2 3 4 5 Genital discomfort
1 2 3 4 5 Reduced sexual energy
1 2 3 4 5 Premature ejaculation
1 2 3 4 5 Seminal emission
1 2 3 4 5 Impotence
1 2 3 4 5 Discharge

SLEEP
1 2 3 4 5 Insomnia
1 2 3 4 5 Drowsiness
1 2 3 4 5 Dreaming
1 2 3 4 5 Disrupted
1 2 3 4 5 Other _____

Please indicate all areas of pain