Helios Integrated Medicine

350 Broadway, Suite 100
Boulder, CO 80305
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

Date:_____/_____/_____

Patient Name: _____

Address:_____City: _____

State:_____Zip: _____

Primary Phone: (_____)_____-_____Alternative Phone: (____)_____-_____

Email Address: _____

Is it ok to leave a voice mail at these numbers? Yes_____No _____

Date of birth:_____/_____/_____Age _____ Gender: _____

Social Security Number (optional) _____

Credit card Number (optional) _____

Expiration date:_____CVV Code _____

Who to notify in an emergency:
Name:_____Relationship: _____

Address: _____

City:_____State:_____Zip: _____

Phone number: (____)_____-_____ Alternative Phone: (____)_____-_____

____I understand that payment is due at the time of service.

____I understand that I am ultimately responsible for payment of services and/or supplies.

____I understand that I am responsible for understanding my individual insurance coverage.

____I will make any dispute of charges at the time of service. All charges will remain as charged on the day of service.

____I understand that I WILL be charged a fee for appointments that are not cancelled within 24 hours.

____I understand that I WILL be charged a maximum fee of $25.00 for each returned check.

Signature:_____Date:_____/_____/_____

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1/1/11

Cancellation Policy

Our practitioners often schedule 30 minute and 1 hour appointments to best meet your medical needs. This limits how many clients we can accommodate in a certain day. Frequently, there are clients who are waiting on lists when appointments become available. We, therefore, have and enforce a 24 hour cancellation/reschedule policy.

We ask that you be considerate to our practitioners and waiting patients. If you need to change your appointment we need 24 hours notice. If you need to change a Monday appointment, it needs to be done by Friday morning. There will be a $100.00 fee when less than 24 hours notice is given. Failure to notify us of a cancellation will result in being charged the full fee for service.

No charge is made for any appointment cancellation or reschedule with more than 24 hours notice. Please arrive 15 minutes prior to your appointment to allow for parking and checking in. We thank you for your compliance and understanding.

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I have read and comply with the above policy.

Signature _____

Date_____/_____/_____

Credit Card Number_____

Exp Date_____/_____/_____

(credit card information optional)

We will notify you prior to your card being charged. We try our best to avoid cancellation or reschedule fees by calling to confirm your appointment.

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Who may we thank for referring you to Helios?
(Please include their name for a gift)

Friend/Family: _____

Practitioner: _____

Other_____

Internet (which site) _____

Our Website ☐ Nexus ☐ Daily Camera ☐

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Adult Health History Form
Date:____/____/_____

Name:_____Date of birth:____/____/____

Allergies to medications _____

_____

Medications & Dosage:

_____
_____
_____
_____
_____
_____

Supplements:

_____
_____
_____
_____
_____
_____

Medical History:

	Good health	Poor health	Deceased	Cause of death	Stroke	Osteoporosis	Asthma/ allergies	Alcoholism	Depression	Diabetes	Kidney/ Bladder Trouble	Dementia	Cancer	Thyroid Disorder	Arthritis	Anxiety	Anemia	Heart Trouble	Hypertension	High Cholesterol	Stomach Trouble
Father																					
Mother																					
Siblings																					
Grandparents																					
Spouse																					
Children																					

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General:

Energy during the day: High ☐ Medium ☐ Low ☐
Exercise tolerance: Good ☐ Okay ☐ Poor ☐

What do you do for exercise, and how often? _____

_____

Any weight changes within the last year?_____If so, how much? _____
Do you use a seat belt? _____
Do you use a cell phone while driving? _____

Nervous System:

__Depression _Startle easily __Flatness __Migraines

__Anxiety __Addictive behavior___Seizures
__Irritability _Motivation __Concussion If so, when? _____

Do you use tobacco?_____If so, how much and for how long? _____

Recreational drug use?____If so, please list: _____

Men:

How often do you get up to urinate at night? _____
Erection problems___
Groin pain___
Testicular pain___
Do you perform self testicular exams? ___
Libido problems___
Sexually active: Yes ☐ No ☐
Prostatitis: Yes ☐ No ☐
Have you ever had an elevated PSA test: Yes ☐ No ☐ If so, what were the results? _____

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Women:

Do you have PMS symptoms?____Please describe if so: _____

Recurrent yeast infections: Yes☐ No ☐

Birth control method_____For how long? _____

Do you perform self breast exams regularly? ____

Have you ever been pregnant?____How many times? ____

Miscarriages____

Abortions ____

Living children____

Have you ever had an abnormal pap smear?____When? _____

Did you receive treatment for an abnormal pap smear? _____

Have you ever had a pelvic infection?____When? _____

Any problems or pain with intercourse?____If so, please describe _____

Do you use any vaginal hormones? _____

Cardiovascular:

__Elevated blood pressure
__Heart palpitations
__Diabetes
__Heart murmur
__Elevated cholesterol
__Chest pain

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Patient Name:_____

Genitourinary:

__Urine leakage/incontinence
__Kidney stones
__Kidney infections
__Urinary tract infections
__Herpes Infections
__History of STD's If so, please list: _____

Pulmonary:

__Asthma
__Shortness of breath
__Cough
__History of bronchitis/pneumonia

Muscles/Joints:

__Arthritis
__Gout
__Headaches
__Back Pain Where? _____
__Broken Bones When? _____

Thyroid:

__Temperature sensitive
__Constipation
__Fatigue
__Dry skin
__Weight gain
__Hair loss

ENT:

__Throat clearing
__Glaucoma
__Cataracts
__Tonsillitis
__Sinus infections
__Airborne allergies
__Hay Fever
__Tonsillectomy

Skin:

__Acne __Eczema __Skin cancer

Gut:

__Gas
__Heartburn
__Constipation
__Blood in stool
__Crohn's Disease
__Bloating
__Belly pain
__Diarrhea
__Colitis
__Belching
__Anemia
__Hemorrhoids
__Ulcers
__Parasitic infection
__Diverticulitis

# of BM's per day ____

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Sleep:

Time to bed _____ Awaken at _____

How do you feel in the morning? _____

Do you use sleep aids? If so, please list._____

_____

__Startle awake __Gasping for air __Shortness of breath
__Trouble going to sleep __Trouble waking up___Observed apneas
__Snoring

Trauma:

__Motor vehicle accident(s)
__Other_____

Hospitalizations Year Type Complications

_____

_____

_____

Diet:

Are you avoiding any foods? If so, please list._____

__Food intolerance
__Food allergies

Do you drink alcohol?___How many drinks per week? _____

Do you drink caffeine?___How often? _____

What do you do to relax? _____

Who is you biggest emotional support? _____

What is your biggest stressor? _____

What is your stress level from 1-10 (10 being the highest)? _____

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When was your most recent:

_____Bone density scan
_____Fecal occult test
_____Flu shot
_____Pap smear
_____Vision exam
_____Vitamin D Test
_____Cardiac stresstest

_____Colonoscopy
_____Tetanus shot
_____Mammogram
_____Pneumococcal shot
_____Cholesterol check
_____PSA

Foreign Travel:

Where	When	Illnesses	Vaccines