



# Intuitive Psychology, PLC

...behavioral medicine for body, mind and spirit

5635 North Scottsdale Road Scottsdale, AZ 85250

Phone: 480-261-4061

Email: admin@intuitivepsychologyplc.com

## Confidential Health History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please provide the following information about your general health and your health history.

- Please check  areas of personal health history. Place an X in areas of family history.

<input type="checkbox"/> Alcohol use/Drug use	<input type="checkbox"/> Ear/Nose/Throat Disease or Infection	<input type="checkbox"/> Migraines/Headaches
<input type="checkbox"/> Allergies: Pollen, Dust, Animal	<input type="checkbox"/> Epilepsy/Seizure Disorder, Convulsions	<input type="checkbox"/> Muscle/Tendon Disorders
<input type="checkbox"/> Allergies: Medications	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Prosthetic Implant/Artificial Limbs
<input type="checkbox"/> Asthma, Bronchitis	<input type="checkbox"/> Female Organ Irregularity, Abnormal Pap, Menstrual	<input type="checkbox"/> Reconstructive/Cosmetic surgery
<input type="checkbox"/> Arthritis, Gout	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Eating Disorder: Anorexia, Bulimia	<input type="checkbox"/> Heart Problem or Condition	<input type="checkbox"/> Skin Disorders/Lesions/Cancer
<input type="checkbox"/> Bone/Joint Condition	<input type="checkbox"/> Hepatitis/Liver Disorder	<input type="checkbox"/> Steroid Use: Prednisone, Anabolic
<input type="checkbox"/> Back, Neck, Spine, Disc Problem or injury	<input type="checkbox"/> Hormonal/Thyroid/Pituitary Disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Birth Defects/Deformity	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Tumors, Cysts, Polyps, Growths
<input type="checkbox"/> Blood Disease: Anemia, Leukemia	<input type="checkbox"/> Immune System Disorder, Lupus	<input type="checkbox"/> Ulcers, Digestive Disorders
<input type="checkbox"/> Blood Vessel, Circulation Disorder	<input type="checkbox"/> Stomach/Colon/Chron's Disease	<input type="checkbox"/> Weight Problems
<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Intestinal Disorders	<input type="checkbox"/> Other, explain: <input type="checkbox"/> _____ _____
<input type="checkbox"/> Breast Implants (L/R)	<input type="checkbox"/> Kidney/Urinary Tract Condition or Infection	
<input type="checkbox"/> Broken Bones/Bone Disease	<input type="checkbox"/> Lung Condition or Infection	
<input type="checkbox"/> Cancer of Any Type	<input type="checkbox"/> Male Organ Irregularity or Condition: Prostate, Impotence	
<input type="checkbox"/> Concussion/Head Injury	<input type="checkbox"/> Nervous Sys Cond. Dementia	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental: Nervous, Depression, Anxiety	

Details for items marked above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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Please list all current medications:

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
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 Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_

(If additional space is needed please attach a separate sheet of paper or feel free to use the back of this form)

Please check any of the following areas that you have experienced:

<input type="checkbox"/> Head Injury	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Other neurologic diagnosis
<input type="checkbox"/> Seizures	Explain: _____

Have you ever smoked? \_\_\_Yes \_\_\_No If yes, number of years: \_\_\_\_\_ Typical Daily Use or Quit Date:

\_\_\_\_\_

Do you drink alcohol? \_\_\_Yes \_\_\_No If yes, number of years: \_\_\_\_\_ Typical Daily Use or Quit Date:

\_\_\_\_\_

Please state the primary reason for this visit: \_\_\_\_\_

By signing below you agree to the following: I attest that the information I have provided is true and correct to the best of my knowledge.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Initials