Intuitive Psychology, PLC
...behavioral medicine for body, mind and spirit

5635 N. Scottsdale Rd Suite 170, Scottsdale, AZ, 85250 Phone: (480) 261-4061 Fax: (480) 535-5548 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.

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

Details for items marked above:_____

_____

_____

_____

_____

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Please list all current medications:

Medication Name:_____ Dosage:_____ Frequency:_____

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Medication Name:_____ Dosage:_____ Frequency:_____

Medication Name:_____ Dosage:_____ Frequency:_____

Medication Name:_____ Dosage:_____ Frequency:_____

Medication Name:_____ Dosage:_____ Frequency:_____

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:

□ Head Injury	□ Convulsions
□ Loss of Consciousness	□ Other neurologic diagnosis
□ 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