



Integrative Healthcare Center

PATIENT INFORMATION

Date: _____

Name: _____

Called Name: _____

Address: _____

Female: ___ Male: ___

Age: _____

Birthdate: _____

Single: ___ Married: ___ Divorced: ___

SSN: _____

Occupation: _____

Employer: _____

Employer's Address: _____

Spouse's Name: _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home: _____

Work: _____

Cell: _____

E-Mail Address: _____

(will not be given out)

Supplements taken regularly (and reason):

INSURANCE

Who is responsible for this account:

Relationship to Patient: _____

Cardholder's Name: _____

Birthdate: _____

SSN: _____

Assignment and Release

I understand that I am financially responsible for all charges whether paid or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of the signature on all insurance submissions.

Responsible Party Signature

Date

Surgeries: _____

Major

Injuries: _____

Medications taken regularly (and reason):

Reason for visit: _____

Please check conditions or symptoms you currently have or have had in the past:

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |

Routine physical exercise: Type of exercise: _____
Minutes per day? _____ Times per week? _____

Dietary preferences/restrictions: _____

TOBACCO	AMOUNT	CAFFEINE	AMOUNT	ALCOHOL	AMOUNT
<input type="checkbox"/> Current/Pks per day	_____	<input type="checkbox"/> Coffee	_____	<input type="checkbox"/> Wine	_____
<input type="checkbox"/> Previous/Pks per day	_____	<input type="checkbox"/> Tea	_____	<input type="checkbox"/> Beer	_____
How long has it been since you quit? _____		<input type="checkbox"/> Soda	_____	<input type="checkbox"/> Hard Liquor	_____
		<input type="checkbox"/> Chocolate	_____		

Are there health hazards that you are exposed to at home/work, such as toxic chemicals, dust, fumes, etc?
 Yes No If yes, describe: _____

Do you suffer from any form of arthritis? Yes No Location _____

Do you suffer from headaches? Yes No How often? _____

Do you have persistent stomach pain, indigestion, or trouble with bowel movements, such as constipation or diarrhea? Yes No If yes, describe _____

Do you suffer from specific symptoms of ill health, such as:

Irritability Yes No

Difficulty in concentrating Yes No

Mood Swings Yes No

Dizziness, trembling, palpitations Yes No

Brain fog/loss of mental acuity Yes No

Concerns about your present weight Yes No

Anxiety, sadness, and depression for which there is no situational explanation Yes No

Inexplicable drops in your strength stamina at various times throughout the day Yes No

Is your stress level Low Medium High

WOMEN ONLY

Are you pregnant? Yes No

Date of last menstrual cycle? _____

Are you experiencing any female related complaints at this time? Yes No

Explain: _____

Have you experienced any problems in the past? Yes No

Explain: _____

How many pregnancies? _____ How many births? _____

Did you have any difficulties or complications during pregnancy or delivery? _____

Please record all food and drinks consumed for five consecutive days.

DAY 1

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

DAY 2

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

DAY 3

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

DAY 4
BREAKFAST:

LUNCH:

DINNER:

SNACKS:

DAY5
BREAKFAST:

LUNCH:

DINNER:

SNACKS:

Please list any medications/ supplements you have recently taken and are presently taking

Detoxification and Drainage Questionnaire

Point count	Points
Never or almost never have the symptom	0
Occasionally have it	1
Occasionally have it, effect is severe	2
Frequently have it, effect is not severe	3
Frequently have it, effect is severe	4

Emotions	Points
Irritability	
Nervousness	
Mood swings	
Frequent crying	
Aggressive behavior, i.e., road rage	
Anxiety	
Fear	
Confusion	
*Depression	
*Suicidal thoughts	
Total Emotions	

Skin	Points
Increased sweating, ear wax, oily skin	
Skin rashes	
Brown spots on hands and face	
Boils	
Skin tags (small hanging warts)	
Acne	
Eczema	
Fever blisters	
Warts	
Total Skin	

Ear, Nose and Throat	Points
Increased salivation	
Mouth ulcers	
Common cold	
Sinusitis	
Sore throats	
*Ear infections	
Hay fever	
Loss of smell	
Cough	
Total Ear, Nose and Throat	

Mind and Brain	Points
Hyperactivity	
Stammering when speaking or problem finding words	
Difficulty in concentration	
Difficulty in making decisions	

Headache	
Poor memory	
Poor coordination	
*Compulsive behavior	
*Sleep disturbance	
Memory loss	
Total Mind and Brain	

Digestive System	Points
Loose stools	
Diarrhea	
Heartburn	
Constipation	
Bloating	
Abdominal pain	
Intolerance to certain foods	
Nausea or vomiting	
Severe diarrhea with blood or mucous	
Total Digestive System	

Kidney	Points
Increase in urination frequency and amount	
Needing to get up in the night to pass urine	
*Urinary tract infections and cystitis	
*Kidney stones	
*Blood in the urine	
Total Kidney	

Joints and Muscles	Points
Fleeting muscle aches or joint aches	
Tendinitis (e.g., tennis elbow, golfer's elbow, achilles tendinitis)	
Gout	
Arthritis	
Fibromyalgia	
Total Joints and Muscles	

Metabolism	Points
Feeling of coldness	
Hypoglycemia	
Craving certain foods	
Water retention	
Obesity	
Cellulite	
Total Metabolism	

GRAND TOTAL	
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*These symptoms are indications of conditions that should not be treated with the Heel Detoxification and Drainage protocols alone.

-Heel
www.heelusa.com
1.800.621.7644