



Integrative Healthcare Center

PATIENT INFORMATION

Date: _____

Name: _____

Called Name: _____

Address: _____

Phone: _____

Female: _____ Male: _____

Age: _____

Birth date: _____

SSN: _____

Mother's Name: _____

Mother's Address: _____

Mother's Home Phone: _____

Mother's Cell Phone: _____

Same as above

Father's Name: _____

Father's Address: _____

Father's Home Phone: _____

Father's Cell Phone: _____

Same as above



Are you choosing to utilize insurance for this account?

If yes, please complete the following information for the cardholder:

Name: _____

Birth date: _____

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



Is your child here for a preventative check-up? Yes: _____ No: _____

If no, what is the reason for the visit?

Please check conditions or symptoms your child currently has or has had in the past:

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema/Skin Problems |
| <input type="checkbox"/> Attention Problems/ADD/ADHD | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Bronchitis/Upper Respiratory Infections | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ear Infections | _____ |

Has your child had any major falls/injuries/surgeries?

Please list any medications or vitamins/supplements your child may be taking:

Medications

Vitamins/Supplements

_____	_____
_____	_____
_____	_____

Of doses of antibiotics your child has taken: _____ 6 months _____ during lifetime

Were there any complications in pregnancy or birth of this child?

Any dietary preferences/restrictions your child may have:

Does your child consume any of the following? Please check:

- | | | | |
|------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Juice | <input type="checkbox"/> _____ glasses/day | <input type="checkbox"/> Sugar | <input type="checkbox"/> _____/day |
| <input type="checkbox"/> Soda | <input type="checkbox"/> _____/week | <input type="checkbox"/> Processed Food | <input type="checkbox"/> _____/week |
| <input type="checkbox"/> Milk | <input type="checkbox"/> _____ glasses/day | <input type="checkbox"/> Sweeteners | |
| <input type="checkbox"/> Fast Food | <input type="checkbox"/> _____/week | <input type="checkbox"/> Other _____ | |
-

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