INNER STRENGTH
MEDICAL + WELLNESS

1522 State Street Unit A, Santa Barbara, CA • (805) 665-3835 • IS-Medical.com

Your Personal Health History

Name:________________________________ Date: ___/____/____Email: ____________________________________

Birth Date: ___/____/_____ Gender: M F Other: ____________ Gender Assigned at Birth: _______________

Home/Cell Phone: ___________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: ____

City: ___________________________________ State: _______ Zip: _________________

Employer Name: ____

Spouse or Patient's Guardian Name: _________________________________

Spouse's Employer: ____

Whom may we thank for referring you?

____

Person to Contact in Case of an Emergency:_______________________________________

Emergency Contact Phone #: __________________________________

In case of a medical emergency and the patient is age 15+, is ok to treat in my absence? _______

Parent or Guardian: ____ Date: _____________

Responsible Party

Name of The Person responsible for this account: __________________________

Relationship to Patient: ________________________

Address: ____Home/Cell Phone: ____________________

Email: _______________________________Driver's License #: _____________________________________

Date of Birth: ________________________Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any medical insurance? ☐ Yes ☐ No If yes, complete the following:

Name of the Insured: ____

Relationship to Patient: ______________________________

Birthdate: _____________________ SS#/SIN: ____________________________

Name of Employer: ____ Work Phone _____________

Address of Employer: ______________________________________ State: ______ Zip: _____________

Insurance Company: ___________________________________ Group #: ____________________

Member ID: ______________________________ Union or local #: _______________________________

Insurance Co. Address: ____________________________________ City _____________________

State __________ Zip___________________________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Inner Strength Medical + Wellness as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider*. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X____ Date: ________________________
(Patient signature)

X____
(Pease print patient name)

X____
(Guardian signature if applicable)

History of Present Illness:

What is the reason for your visit today?

____

____

____

Location: ____
(Where is the pain/problem?)

Quality:____________________________________
(Example: normal vs abnormal color, activity, etc.)

Severity: ____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: ___________________________________
(How long have you had this pain/ problem? When did it start?)

Timing: ____
(Does the pain/problem occur at a specific time?)

Context: ___________________________________
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms ____

____

(What other associated problems have you been having?)

Modifying Factors ____

____

(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State

Medication: (include nonprescription)

____

____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

☐ Yes ☐ No If yes what type: ____

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES
Hepatitis	NO	YES	Mumps	NO	YES	Bladder Infection	NO	YES
High Blood Pressure	NO	YES	Ulcer	NO	YES	Chicken Pox	NO	YES
Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraine Headaches	NO	YES	Hemorrhoids	NO	YES
Thyroid Disease	NO	YES	Scarlet Fever	NO	YES	Tuberculosis	NO	YES
Last Chest X-Ray: ___/___/_____			Bleeding Tendency	NO	YES	Diphtheria	NO	YES
Diabetes	NO	YES	Asthma	NO	YES	Small pox	NO	YES
Cancer	NO	YES	Hives of Eczema	NO	YES	Pneumonia	NO	YES
Polio	NO	YES	AIDS & HIV	NO	YES	Rheumatic Fever	NO	YES
Glaucoma	NO	YES	Infectious Mono	NO	YES	Arthritis	NO	YES
Hernia	NO	YES	Bronchitis	NO	YES	STI's	NO	YES
Mitral Valve Prolepses	NO	YES	Stroke	NO	YES			
Blood or Plasma Transfusion	NO	YES						
Any Other Disease	NO	YES	(Please List):					

____

____

Patient Social History:

Marital Status	Single: _______	Married: _______	Separated: _______	Divorced: _______	Widowed: _______
Use of Alcohol	Never: _______	Rarely: ________	Moderate: ________	Daily: __________	
Use of Tobacco	Never: _______	Rarely: ________	Moderate: ________	Daily: __________	
Use of Drugs	Never: _______	Type/Frequency:			

____

Excessive Exposure

At home or at work to: Fumes: ______ Dust: ______ Solvents: ______ Airborne Particles: ______ Noise: ________

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father:	_________	________________________	________________________
Mother:	_________	________________________	________________________
Siblings:	_________	________________________	________________________
	_________	________________________	________________________
	_________	________________________	________________________
Spouse:	_________	________________________	________________________
Children:	_________	________________________	________________________
	_________	________________________	________________________
	_________	________________________	________________________

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5
Diarrhea	1 2 3 4 5
Forgetfulness	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Feeling foggy	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ______________________

Signature of the Patient, Parent or Guardian Date

CLINICIAN SIGNATURE: ____ **DATE REVIEWED**:______________

PATIENT NAME: ____ **DATE**:____________________