

Helios Integrated Medicine

350 Broadway, Suite 100
Boulder, CO 80305
T 303.499.9224
F 303.499.9593
heliosintegratedmedicine.com

Patient Registration

Date: ____/____/____

Patient Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Primary Phone: (____) ____-____ Alternative Phone: (____) ____-____

Email Address: _____

Is it ok to leave a voice mail at these numbers? Yes ___ No ___

Date of birth ____/____/____ Age _____ Gender: Male / Female

Social Security Number (optional): _____ - _____ - _____

Credit card Number (optional) _____

Expiration date: ____/____ CVV Code _____

Who to notify in an emergency:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: (____) ____-____ Alternative Phone: (____) ____-____

- ▶ I understand that payment is due at the time of service.
- ▶ I understand that I am ultimately responsible for payment of services and/or supplies.
- ▶ I understand that I am responsible for understanding my individual insurance coverage.
- ▶ I will make any dispute of charges at the time of service. All charges will remain as charged on the day of service.
- ▶ I understand that I WILL be charged a fee for appointments that are not cancelled within 24 hours.
- ▶ I understand that I WILL be charged a maximum fee of \$25.00 for each returned check.

Signature: _____ Date: ____/____/____

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1/1/11

Cancellation Policy

Our practitioners often schedule 30 minute and 1 hour appointments to best meet your medical needs. This limits how many clients we can accommodate in a certain day. Frequently, there are clients who are waiting on lists when appointments become available. We, therefore, have and enforce a 24 hour cancellation/reschedule policy.

We ask that you be considerate to our practitioners and waiting patients. If you need to change your appointment we need 24 hours notice. If you need to change a Monday appointment, it needs to be done by Friday morning. There will be a \$100.00 fee when less than 24 hours notice is given. Failure to notify us of a cancellation will result in being charged the full fee for service.

No charge is made for any appointment cancellation or reschedule with more than 24 hours notice. Please arrive 15 minutes prior to your appointment to allow for parking and checking in. We thank you for your compliance and understanding.

Helios Integrated Medicine

I have read and comply with the above policy.

Signature _____

Date ____/____/____

Credit Card Number _____

Exp Date ____/____/____

(credit card information optional)

We will notify you prior to your card being charged. We try our best to avoid cancellation or reschedule fees by calling to confirm your appointment.

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Who may we thank for referring you to Helios?
(Please include their name for a gift)

Friend/Family: _____

Practitioner: _____

Other _____

Internet (which site) _____

Our Website

Nexus

Daily Camera

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General:

Energy during the day: High Medium Low

Exercise tolerance: Good Okay Poor

What do you do for exercise, and how often? _____

Any weight changes within the last year? _____ If so, how much? _____

Do you use a seat belt? _____

Do you use a cell phone while driving? _____

Nervous System:

__ Depression __ Startle easily __ Flatness __ Migraines

__ Anxiety __ Addictive behavior __ Seizures

__ Irritability __ Motivation __ Concussion If so, when? _____

Do you use tobacco? _____ If so, how much and for how long? _____

Recreational drug use? _____ If so, please list: _____

Men:

How often do you get up to urinate at night? _____

Erection problems _____

Groin pain _____

Testicular pain _____

Do you perform self testicular exams? _____

Libido problems _____

Sexually active: Yes No

Prostatitis: Yes No

Have you ever had an elevated PSA test: Yes No If so, what were the results? _____

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Women:

Do you have PMS symptoms? ____ Please describe if so: _____

Recurrent yeast infections: Yes No

Birth control method _____ For how long? _____

Do you perform self breast exams regularly? ____

Have you ever been pregnant? ____ How many times? ____

Miscarriages ____

Abortions ____

Living children ____

Have you ever had an abnormal pap smear? ____ When? _____

Did you receive treatment for an abnormal pap smear? _____

Have you ever had a pelvic infection? ____ When? _____

Any problems or pain with intercourse? ____ If so, please describe _____

Do you use any vaginal hormones? _____

Cardiovascular:

- | | |
|--|---|
| <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Elevated cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chest pain |

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Patient Name: _____

Genitourinary:

- | | |
|---|---|
| <input type="checkbox"/> Urine leakage/incontinence | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Herpes Infections |
| <input type="checkbox"/> Kidney infections | <input type="checkbox"/> History of STD's If so, please list: _____ |

Pulmonary:

- Asthma
- Shortness of breath
- Cough
- History of bronchitis/pneumonia

Muscles/Joints:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain Where? _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Broken Bones When? _____ |
| <input type="checkbox"/> Headaches | |

Thyroid:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Temperature sensitive | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hair loss |

ENT:

- | | |
|--|---|
| <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Airborne allergies |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tonsillectomy |

Skin:

- Acne Eczema Skin cancer

Gut:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Belly pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Colitis | <input type="checkbox"/> Parasitic infection |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Belching | <input type="checkbox"/> Diverticulitis |

of BM's per day _____

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Sleep:

Time to bed _____ Awaken at _____

How do you feel in the morning? _____

Do you use sleep aids? If so, please list. _____

- Startle awake
- Trouble going to sleep
- Snoring
- Gasping for air
- Trouble waking up
- Shortness of breath
- Observed apneas

Trauma:

- Motor vehicle accident(s)
- Other _____

Hospitalizations	Year	Type	Complications
------------------	------	------	---------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Diet:

Are you avoiding any foods? If so, please list. _____

- Food intolerance
- Food allergies

Do you drink alcohol? ___ How many drinks per week? _____

Do you drink caffeine? ___ How often? _____

What do you do to relax? _____

Who is your biggest emotional support? _____

What is your biggest stressor? _____

What is your stress level from 1-10 (10 being the highest)? _____

