Helios Integrated Medicine

2525 4th Street
Boulder, CO 80304
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.

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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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Adult Health History Form
Date: _____/_____/_____

Name: _____Date of birth: ____/____/____

Allergies to medications _____

_____

Medications & Dosage:

_____
_____
_____
_____
_____
_____

Supplements:

_____
_____
_____
_____
_____
_____

Medical History:

	Good health	Poor health	Deceased	Cause of death	Stroke	Osteoporosis	Asthma/ allergies	Alcoholism	Depression	Diabetes	Kidney/ Bladder Trouble	Dementia	Cancer	Thyroid Disorder	Arthritis	Anxiety	Anemia	Heart Trouble	Hypertension	High Cholesterol	Stomach Trouble
Father																					
Mother																					
Siblings																					
Grandparents																					
Spouse																					
Children																					

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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:

__ Elevated blood pressure
__ Heart palpitations
__ Diabetes
__ Heart murmur
__ Elevated cholesterol
__ Chest pain

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Patient Name:_____

Genitourinary:

__ Urine leakage/incontinence
__ Kidney stones
__ Kidney infections
__ Urinary tract infections
__ Herpes Infections
__ History of STD's If so, please list: _____

Pulmonary:

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

Muscles/Joints:

__ Arthritis
__ Gout
__ Headaches
__ Back Pain Where? _____
__ Broken Bones When? _____

Thyroid:

__ Temperature sensitive
__ Constipation
__ Fatigue
__ Dry skin
__ Weight gain
__ Hair loss

ENT:

__ Throat clearing
__ Glaucoma
__ Cataracts
__ Tonsillitis
__ Sinus infections
__ Airborne allergies
__ Hay Fever
__ Tonsillectomy

Skin:

__ Acne __ Eczema __ Skin cancer

Gut:

__ Gas
__ Heartburn
__ Constipation
__ Blood in stool
__ Crohn's Disease
__ Bloating
__ Belly pain
__ Diarrhea
__ Colitis
__ Belching
__ Anemia
__ Hemorrhoids
__ Ulcers
__ Parasitic infection
__ 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 __ Gasping for air __ Shortness of breath
__ Trouble going to sleep __ Trouble waking up __ Observed apneas
__ Snoring

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 you biggest emotional support? _____

What is your biggest stressor? _____

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

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When was your most recent:

_____Bone density scan
_____ Fecal occult test
_____ Flu shot
_____ Pap smear
_____ Vision exam
_____ Vitamin D Test
_____ Cardiac stress test

_____Colonoscopy
_____ Tetanus shot
_____ Mammogram
_____ Pneumococcal shot
_____ Cholesterol check
_____ PSA

Foreign Travel:

Where	When	Illnesses	Vaccines