Chelation Medical Center, LLC "Solutions for Life"

PATIENT PERSONAL INFORMATION

www.ChelationMedicalCenter.com

Patient's full name: _____ Today's date: ___/___ /___

Address: _____ Birth date ____/____/____ Sex: M / F

_____ Age: ____ marital status _____

Home phone: (____) _____ Work: (____) _____ Cell: _____

E-Mail _____ SSN (optional) _____

Spouse's or Parent's name(s) _____

Who referred you or how did you hear about us? _____

FINANCIAL INFORMATION: responsible party name: _____

Relationship _____ address (if different) _____

IN CASE OF EMERGENCY NOTIFY: _____ Phone (____)_____

Payment for Services:

Payment is due at the time services are rendered. Insurance filing is the responsibility of the patient/guardian. We will provide a billing statement receipt for you with diagnostic and procedural codes which you may submit to your insurance provider. We do not accept Medicare or MaineCare assignment of benefits.

Primary Care Doctor: _____ phone # _____

We recommend that our patients have a primary care physician for routine problems, acute illness and hospital admissions. If you agree to have Dr. Psonak discuss medical issues with your primary care doctor, sign here: _____ date: ___/___/___

I UNDERSTAND that the approach of Chelation Medical Center, LLC and Dr. Psonak to medical problems is from a perspective that may differ from what may be considered the conventional or standard therapy of the medical community.

I acknowledge by my signature below that I have had no drug-related felonies in the past 10 years.

I also understand that the office is ***fragrance free. Anyone entering the office must avoid the use of perfume, after-shave, fragrances or residue of smoke on their clothes, otherwise they will be asked to leave and another appointment will be set for them. Please ask if you should come in fasting for your visit.***

Patient or Guardian Signature: _____ Date: ___/___ /____

Medical History

Today's Date _____

Patient Name_____ Date of Birth _____

Your Height: _____ Your Weight: _____

Main Problems (Chief Complaint):

List the main problems that you wish to address - current medical problems/date started

_____

_____

_____

_____

_____

YOUR SYMPTOMS (History of Main Problems):

Please list any symptoms that you have now or experienced: (Please check past or present and how severe and frequent the problem)

		Past	Present	How severe	How Frequent
1.	Headaches	☐	☐		
2.	Problems with vision, hearing, taste or smell	☐	☐		
3.	Chest Pain or shortness of breath	☐	☐		
4.	Cough, wheezing or other difficulties	☐	☐		
5.	Heartburn, gas, bloating, indigestion	☐	☐		
6.	Constipation, diarrhea, hemorrhoids	☐	☐		
7.	Urinary tract problems, stones, infections in the bladder or kidney	☐	☐		
8.	Gynecologic problems(specify)	☐	☐		
9.	Infertility, impotence, low libido	☐	☐		
10.	Skin or hair problems	☐	☐		
11.	Bone or joint disorders	☐	☐		
12.	Neurological problems, Fasciculations	☐	☐		
13.	Mood, emotion, or psychiatric problems	☐	☐		
14.	Fatigue, night sweats, loss of motivation	☐	☐		

Allergies or adverse drug reactions: (List Known Allergies to medication and type of reactions)

_____

_____

Other Allergies: Check all that apply:

☐ Dairy ☐ Wheat ☐ Corn ☐ Eggs ☐ Peanuts ☐ shellfish ☐ Chemicals ☐ DON'T KNOW

Do you react to pollen? ☐ Yes ☐ No Reaction _____

Do you react to molds? ☐ Yes ☐ No Reaction _____

Do you react to foods? ☐ Yes ☐ No Reaction _____

Blood Type: Do you know your blood type? (Circle One) O A B AB (Circle One) Positive or Negative

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

NUTRITIONAL & HERBAL PREPARATIONS

Preparation	Dose	How often taken

Habits: Do you smoke? No_____ Yes_____

If yes, how many packs per day?_____

If you have quit, how long ago? _____

Do you use alcohol? No_____ Yes_____

If yes, how often do you drink?_____

Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

Please indicate past or present amounts:

	Daily	Weekly	Occasionally	Never	Past
Coffee/caffeine					
Aspirin					
Laxatives					
Exercise					
Meditation					

ILLNESSES & DISEASES (Past Medical History):

Date of last complete checkup _____ Results _____

Names of recent Doctors consulted _____

PAST MEDICAL HISTORY:

Please list all Accidents and Injuries:

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list any surgeries (operations), reason for the surgery, and date of surgery:

FAMILY HISTORY: Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Allergies								
Asthma								
Cancer (specify)								
Heart disease								
Stroke								
Lung disease (specify)								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Neurologic disease (specify)								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

REVIEW OF SYSTEMS:

SYMPTOM REVIEW

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ abnormal Pap smear
- ☐ bleeding between periods
- date of last mammogram_____

Men only
- ☐ Elevated PSA

Anything else?
- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

WORK HISTORY

Current Occupation: _____ How Long? _____

Past Occupations: _____ How long? _____

_____ How long? _____

****

Thank you for taking the time to complete this form.

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT

It is the beginning of your process of healing and good health!