Integrated
Complementary &
Alternative
Medicine Institute of Amarillo, LLC

1901 Medi-Park Suite 1001 806 468-4616 Fax: 806 468-4618
Amarillo, TX 79106

REGISTRATION

Name:_____ **Date of Birth** _____ M / F
Last First Middle
IF Minor Also give parent's name:

Address:_____ **City:** _____ **State**:___ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

e – mail: _____ Marital Status: M S D W ___

Occupation: _____ Employer: _____

If retired – Previous Occupation_____

Spouse's Name: _____ **Date of Birth** _____
Last First Middle

Occupation: _____ Employer: _____

If retired – Previous Occupation_____

Please provide **insurance information** for purposes of potential diagnostic tests and referrals. ICAM staff will make a photo copy of your insurance card – Thank you

CONSENT TO TREAT:

The undersigned consents to receive integrated, complementary & alternative health care services provided by health care practitioners. Specific services may include diagnostic procedures, examinations, treatments, or other services rendered under the special instructions of the practitioners.

The undersigned understands that treatment modalities offered at ICAM may differ from conventional allopathic medicine. .

Signature: _____ Date: _____

Witness: _____ Date: _____

Note: Payment is expected at time of services rendered and is the responsibility of the client. Clients may submit charges to their insurance carrier, with the understanding that services may or may not be covered.

Client Health History

Name:_____ **Date:** _____

Date of Birth:_____ Age: _____ Gender: M/F Marital Status: S M D W

How did you learn about ICAM?_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Height: _____ Weight: Currently:_____ Past Maximum: _____ When? _____ Pulse: _____

Blood Pressure: _____ Other: _____

Primary Health Care Provider: _____ **Other Specialists:** _____

What health concerns bring you to ICAM? _____

1. Please identify the health concerns that have brought you to ICAM in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	_____
c. _____	_____
How does this condition affect you? _____	

2. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction)

_____

_____

_____

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking (including dosage and frequency per day):

_____

_____

_____

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4. Do you have any reason to believe you may be pregnant? Y N

Past Pregnancies: Age:_____ Age:_____

Age:_____ Age:_____

5. Do you have any infectious diseases? Y N If YES, please specify: _____

6. **Family History:** Father Mother Brothers Sisters Spouse Children

Check those applicable:

Age(if living)	_____	_____	_____	_____	_____	_____
Health(G=good	_____	_____	_____	_____	_____	_____
P=Poor) Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

Other _____

7. **Childhood Illness** (please underline any you had in the past):

Scarlet Fever Rheumatic Fever Mumps Measles German Measles Chicken pox

Childhood Immunizations: _____

8. **Emotional** (circle any that you experience **now** / underline any that you have experienced in the past:

Mood swings Nervousness Mental Tension Anxiety

9. **Energy and Immunity** (circle any that you experience **now** / underline any that you experienced in the past)

Fatigue Slow wound healing Chronic Infections Chronic Fatigue Syndrome

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10. **Head, Eye, Ear, Nose, and Throat** (circle any that you experience **now** / underline any that you experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ Problems	Hay Fever

11. **Respiratory** (circle any that you experience **now** / underline any that you experienced in the past):

Pneumonia	Frequent common colds	Difficulty Breathing	Emphysema
Persistent Cough Pleurisy		Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

12. **Cardiovascular** (circle any that you experience **now** / underline any that you experienced in the past):

Heart Disease	Chest Pain	Swelling Ankles	High Blood Pressure
Palpitations/Fluttering	Stroke	Heart Murmurs Rheumatic Fever	Varicose Veins

13. **Gastrointestinal** (circle any that you experience **now** / underline any that you experienced in the past):

Ulcers	Changes in Appetite (INCREAE /DECREASE)		Nausea/Vomiting		Epigastric Pain
Passing Gas	Heartburn	Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C
Hemorrhoids	Abdominal Pain	Flatulence	Bloating		

14. **Genito-Urinary Tract** (circle any that you experience **now** / underline any that you experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

15. **Female Reproductive/Breasts** (circle any that you experience **now** / underline any that you experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow	Vaginal Discharge
Premenstrual Problems	Clotting	Bleeding Between Cycles	Menopausal Symptoms	
Difficulty Conceiving	Painful Periods			

16. **Male Reproductive** (circle any that you experience now / underline any that you experienced in the past)**:**

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge

17. **Musculoskeletal** (circle any that you experience **now** / underline any that you experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain
Mid Back Pain	Low Back Pain	Leg Pain	Joint Pain (where?)_____

18. **Neurologic** (circle any that you experience **now** / underline any that you experienced in the past):

Vetigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

19. **Endocrine** (circle any that you experience **now** / underline any that you experienced in the past):Hypothyroid

Hypoglycemia Diabetes Mellitus Night Sweats Feeling Hot or Cold

22. **Other** (circle any that you experience **now** / underline any that you experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

21. **Dental Issues** **Which teeth?**

- Do you have any silver (amalgam) fillings ? Y N _____
- Do you have any root canals ? Y N _____
- Do you have any implants ? Y N _____
- Have you had any extractions ? Y N _____

Is there anything else we should know? _____

22. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many?_____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

Do you fall asleep quickly? Y N Do you sleep through the night? Y N

e. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not? _____

f. Nicotine/Alcohol/Caffeine Use: _____

g. Have you experienced any physical or emotional traumas? Y N Explain:

h. How much water do you drink per day? _____

i. Do you have a bowel movement every day? Y N

23. **Surgery/Hospitalizations Age**

_____

_____

_____

25. **Toxic profession/Exposure past or present**

_____

_____

_____

26. **Please write down the location of any scars on your body**

Location Date/Reason

_____

_____

_____

_____

27. **Please write down any other information that you believe is important for us to know.**

_____

_____

_____

_____

THANK YOU

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ICAM – DIET HISOTRY FORM (Please complete for 3 days)

NAME: _____

DATE	BREAKFAST	LUNCH	DINNER	SNACKS
DAY 1 / /				
DAY 2 / /				
DAY 3 / /				

Medical Record Release Authorization

Patient Name: _____

Legal Guardian (if applicable): _____

Date: _____

I, _____ (please print full name), authorize ICAM Institute of Amarillo, LLC to release any and all medical records to myself via fax, email, or mail. I realize that any fax or email may be sent un-encrypted. I also authorize the following person(s) to request this information on my behalf, as well as discuss patient medical records.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ICAM may disclose the following information (please check **ALL 3** to give us full permission to send any part of your chart):

☐ Entire medical record ☐ Test Results ☐ Most Recent Chart Note

This authorization is in force 12 months from the date listed above.

Signature of patient: _____

Signature of legal guardian (if applicable): _____

----------**OR**----------

****ONLY SIGN BELOW IF YOU ARE DENYING THE ABOVE AUTHORIZATION****

I, _____ (please print full name), request that patient medical records only be released upon my request via my physical presence in the office of ICAM Institute of Amarillo, LLC.

This authorization is in force 12 months from the date listed above.

Signature of patient: _____

Signature of legal guardian (if applicable): _____