8830 Long Point Road Ste. 105
Houston, TX 77055
713-932-0240

Personal Information	Date:

Name: _____

Date of Birth:_____ **Social Security No**: _____ **Marital Status**: _____

Home Address: _____
City **State** **Zip Code**

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

E-mail (Home): _____ **Preferred Method of Contact:**_____

Referred by: _____ **Other Doctors:** _____

Primary person to be notified in case of an emergency:

Name: _____

Relationship: Relative_____ **Friend**_____ **Other**_____

Home Address: _____
City **State** **Zip Code**

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

E-mail Address: _____

Insurance Information:

Insurance Company:_____

Subscriber Name _____ **Date of Birth:** _____/_____/_____

Subscriber ID: _____ **Group/Plan Number:** _____

Employer/Group Name: _____

PLEASE BE ADVISED THAT WE ARE UNABLE TO BILL ANY INSURANCE ACCEPTED BY OUR OFFICE WITHOUT A COPY OF THE CURRENT INSURANCE CARD. Also, in the event your insurance company denies the claim for ANY reason, you will be personally responsible for the charges incurred.

Assignment of Benefits: I authorize assignment of all medical insurance benefits to the named provider for the medical services rendered.

Signature: _____ Date: _____

Assignment to pay for Services: I agree to pay Green Health Clinic for all charges for services rendered to the patient today, or any future date of service in the office. I understand payment in full and/or co-pay and/or co-insurance is expected at the time of services rendered. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorneys' fees and/or court costs.

Signature: _____ Date: _____

Please list all doctors you have seen in the last 5 years

Doctor's Name	Address	Phone	Reason for visits

Medications: List all medications currently taking:

Medication	Dosage	Times per day	Reason for taking

List any to which you are allergic:

Medication	Type of Reaction
Food allergies	
Environmental allergies	

Social History

Has this or any job put you around strong chemicals or smoke? Yes No

Tobacco:	Yes	No	How many per day? How many years?
Currently smoking:	Yes	No	If quit, how long ago?
Smoke exposure at home:	Yes	No	
Alcohol:	Yes	No	How many drinks per week? How many years?

Past Surgical History: Yes _____ None _____

List year performed next to surgery. Fill in those not listed at the end.

- ☐ Appendix:
- ☐ Tubal Ligation:
- ☐ Gall bladder:
- ☐ Cardiac: Catheterization:
- ☐ Tonsils:
- ☐ Spinal Fusion:
- ☐ Sinus surgery:
- ☐ Joint Replacement: Which joint: ___
- ☐ Tubes in ears:
- ☐ Hysterectomy: Check one: Total / Partial
- ☐ Other: _____

Past Medical History: **please check all that apply fill in any not listed at the end **

- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding
- ☐ Disorder
- ☐ Blood Clot(s)
- ☐ Breast Disease
- ☐ Broken Bone
- ☐ Cancer: Type
- ☐ Chronic Fatigue
- ☐ Chronic Pain: where
- ☐ Chronic Sinusitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrea
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Weight loss / Gain:
- ☐ Impotence
- ☐ Irritable Bowels
- ☐ Kidney Disease
- ☐ Low Testosterone
- ☐ Menopause
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Panic Disorder
- ☐ Prostate Enlargement
- ☐ Reflux (GERD)
- ☐ Seizures
- ☐ Stroke
- ☐ Urinary Tract Infection
- ☐ Mental disorder:

Please check any symptoms or concerns you have now.

Constitutional

- ☐ Good general health
- ☐ Recent weight change
- ☐ Headaches
- ☐ Fever

Ear/Nose/Throat

- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

Eyes

- ☐ Eye disease or injury
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Double/blurred vision

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Palpitations
- ☐ Shortness of breath lying flat
- ☐ Swelling of extremities

Respiratory

- ☐ Chronic or frequent cough
- ☐ Shortness of breath

Gastrointestinal

- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Painful bowel movement
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Abdominal pain

Hematology

- ☐ Bleeding or bruising
- ☐ Anemia
- ☐ Past transfusion

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Change if force of urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Male---testicle pain
- ☐ Female---irregular menses

Neurological

- ☐ Frequent headaches
- ☐ Lightheaded/dizzy
- ☐ Convulsions
- ☐ Numbness/tingling

Musculoskeletal

- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Weak muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty in walking

Skin/Breast

- ☐ Cold hands or feet
- ☐ Hives
- ☐ Rash or itching
- ☐ Hair loss
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump

Psychiatric

- ☐ Memory loss/confusion
- ☐ Nervousness/Anxiety
- ☐ Depression/Mania
- ☐ Addictive behavior

Endocrine

- ☐ Excessive thirst/urination
- ☐ Sugar cravings
- ☐ Hot/cold intolerance
- ☐ Poor sex drive
- ☐ Dry skin

- ☐ Asthma or wheezing
- ☐ Tremors

Energy

- ☐ Head injury

Sleep

- ☐ Problems falling asleep

- ☐ Forgetful
- ☐ Poor concentration
- ☐ Fatigue
- ☐ Worst time of day:_____
- ☐ Problems staying asleep
- ☐ Snore
- ☐ Restless legs

Activities of Daily Living Assessment:

Please check if any of the following activities are substantially limited (i.e., pain/weakness/impaired strength or ability) by the medical condition for which you seek medical attention?

- ☐ caring for myself
- ☐ hearing
- ☐ lifting
- ☐ bending
- ☐ learning
- ☐ thinking
- ☐ social interaction
- ☐ performing manual tasks
- ☐ eating
- ☐ standing
- ☐ reading
- ☐ communicating
- ☐ seeing
- ☐ sleeping
- ☐ lifting
- ☐ breathing
- ☐ concentrating
- ☐ working
- ☐ operation of major bodily function
- ☐ other (please specify)

Family Medical History:

To the best of your knowledge, have any blood relatives been diagnosed with the following (Please state the family member(s) in the space provided):

- ☐ Alcoholism
- ☐ Depression
- ☐ Allergies
- ☐ Diabetes
- ☐ Alzheimer's
- ☐ Epilepsy
- ☐ Anemia
- ☐ Stroke
- ☐ Cancer Member/Type: _____/_____
  Member/Type: _____/_____
  Member/Type: _____/_____
- ☐ Heart Disease
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Birth Defect
- ☐ High Cholesterol
- ☐ Bleeding Disorder
- ☐ Kidney Disease

Spiritual Life:

Having an active spiritual or religious life is an important part of overall health.

Describe your current religious practice (please provide details as to how often and what you do. For example, do you attend church or other ceremony? Any small group studies?)

Client Two Day Food Diary

Green Health Clinic believes very strongly that the food you put in your body plays a large role in your health; both positively and negatively. A food diary is a very valuable resource for determining your current level of nutrition. It will allow us to make recommendations for improvement, as well as consider the possibility of some groups of foods that may be causing symptoms.

Please choose two days to record all of your intake. These days should be considered "normal", don't choose days where your foods are drastically different from usual. Try to record intake for at least one weekday and one weekend day, because food choices can be different. This is preferred but not necessary.

Meal	Day 1	Day 2
Breakfast		
Lunch		
Dinner		
Snacks		
Beverages (soda, coffee, etc.)		

Goals:

Please list the reasons you have come to Green Health Clinic.

1._____

2._____

3._____