Adult History Form

Nu-Life Wellness Centre

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NOTE : This is a confidential record and will be kept in this facility of your doctor's office. Information contained here will not be released to any one without your authorisation to do so.

Patient General Information Date : ______________

Name : ____________________________________ Date of Birth ________________ Age _______

Gender: __________ Occupation____________________________Birth place__________________

Permanent Address : ____

____

____

Marital Status Single / Married / Divorced / Separated / Widow / Widower

Spouse's Name __________________________

Your Doctor: _____________________________Referred by: ______________________________

Phone numbers : Home:___________________________Office :_____________________________

Mobile:__________________________ Email address_____________________________________

List all States and Countries in which you have lived

____

____

Date of last Physical examination: ____

Doctors you have seen for your problems:

MD [ ] Specialist [ ] Acupuncturist [ ] Nutritionist [ ] Psychiatrist [ ] Psychologist [ ]
Others ____

INFORMED CONSENT FOR TREATMENT for Dr. K. ARUL MBBS., FPC., FMMC.,

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you, it is simply to inform you that you may give or withhold your consent to treatment.

If you refuse any specific procedure this will not affect your receiving other care or future Treatments.

I voluntarily request Dr. K. Arul as my Doctor to examine and treat me and my health conditions. I understand that the course of therapy may include the use of multiple modalities of Integrative medicine including nutritional supplements, injection therapies, prolotherapy, Platelet Rich Plasma, EECP, intravenous nutrients, chelation, medical ozone and other therapies offered by Dr. K. Arul. I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing consent to treatment for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition, discuss Integrative and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that payment is due in full at the time of service. I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.

All information given now or at any point in the future is confidential. It is Integrative Physicians Group's policy to require a medical release form before releasing medical records to anyone other than the patient.

I certify that I have read this form / have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name : Date :

Patient Signature ________________________

Guardian Signature ________________________

Physician's Signature ________________________

Photograph…………… Browse…..

Chief Complaints : (Please list all symptoms)

____

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FAMILY HISTORY

Has Any Blood Relative Ever had?

Condition						
Cancer including Leukemia		NO		YES	WHO	
Tuberculosis		NO		YES	WHO	
Diabetes		NO		YES	WHO	
Heart Attack		NO		YES	WHO	
High Blood Pressure		NO		YES	WHO	
Stroke		NO		YES	WHO	
Epilepsy		NO		YES	WHO	
Bleeding Disorder		NO		YES	WHO	
Asthma		NO		YES	WHO	
Allergies		NO		YES	WHO	
Liver Disease		NO		YES	WHO	
Migraine, Headaches		NO		YES	WHO	
Alcoholism		NO		YES	WHO	
Emphysema		NO		YES	WHO	
Stomach or Duodenal Ulcer		NO		YES	WHO	
Kidney Disease		NO		YES	WHO	
Glaucoma		NO		YES	WHO	
Mental Illness		NO		YES	WHO	
Suicide		NO		YES	WHO	

	Living	**Age**	**Dead**	**Age**	**Cause of Death**
Father					
Mother					
Brother or Sister					
Husband or Wife					
Son or Daughter					

PERSONAL HISTORY

Do you smoke?	[ ] NO	[ ] YES	
If yes, what? How much?	____________________		
Did you ever smoke?	[ ] NO	[ ] YES	
	[ ] STOPPED		
Do you drink?	[ ] NO	[ ] YES	
- Beer	[ ] NO	[ ] YES	
- Wine	[ ] NO	[ ] YES	
- Other alcoholic beverages	[ ] NO	[ ] YES	
How much of each?	____________________		

Living Situation

Are you under stress? _____Yes ____ No

Are you over weight? _____Yes ____ No

Do you like your job? _____Yes ____ No

Do you exercise regularly? _____Yes ____ No, If Yes, how often? ______________________

Do you have pets? _____Yes ____ No, If Yes, _______Dog ______ Cat _______ Bird _______ Other

Animals in the house? _____Yes _____ No. Animals in the bedroom? _____ Yes _____No

OPERATIONS

Surgical history, if any please mention: _________ __________ ________

HEART AND VESSELS

Angioplasty Heart	[ ] NO	[ ] YES	WHEN	
Limb Vessels	[ ] NO	[ ] YES	WHEN	
Carotids	[ ] NO	[ ] YES	WHEN	
Other Vessels:________	[ ] NO	[ ] YES	WHEN	
Bypass Surgery	[ ] NO	[ ] YES	WHEN	

PERSONAL HISTORY

DRINKING HABITS

Item						
Coffee		NO		YES		cups day
De-caf		NO		YES		cups day
Tea		NO		YES		cups day
Herb tea		NO		YES		cups day
Juice		NO		YES		cups day
Milk		NO		YES		cups day
Water		NO		YES		ml day
- Tap		NO		YES		ml day
- Filtered		NO		YES		ml day
- Plastic Bottled		NO		YES		ml day
- Glass Bottled		NO		YES		ml day
Soft Drinks		NO		YES		ml day

DIETARY HABITS

Item						
Lamb		NO		YES		times / week
Pork		NO		YES		times / week
Beef		NO		YES		times / week
Chicken		NO		YES		times / week
- Caged		NO		YES		times / week
- Free Bird		NO		YES		times / week
Fish		NO		YES		times / week
Organ Meats		NO		YES		times / week
Fruit		NO		YES		times / week
Vegetables		NO		YES		times / week
- Raw		NO		YES		times / week
- Boiled		NO		YES		times / week
- Deep Fried		NO		YES		times / week

VERIFY PRESENT SYMPTOMS: Please Tick

WOMEN ONLY (At the time of your period, tick all that apply)

Symptom								
Fluid Retention		NO		YES HAVE NOW		YES PAST	WHEN	
Cramps		NO		YES HAVE NOW		YES PAST	WHEN	
PMS		NO		YES HAVE NOW		YES PAST	WHEN	
Depressed		NO		YES HAVE NOW		YES PAST	WHEN	
Irritable		NO		YES HAVE NOW		YES PAST	WHEN	
Heavy Bleeding		NO		YES HAVE NOW		YES PAST	WHEN	
Appetite Change		NO		YES HAVE NOW		YES PAST	WHEN	
Irregular Flow		NO		YES HAVE NOW		YES PAST	WHEN	
Irregular Period		NO		YES HAVE NOW		YES PAST	WHEN	
Vaginal itching		NO		YES HAVE NOW		YES PAST	WHEN	
Yeast Infection		NO		YES HAVE NOW		YES PAST	WHEN	
Vaginal Discharge		NO		YES HAVE NOW		YES PAST	WHEN	
Bleeding between Periods		NO		YES HAVE NOW		YES PAST	WHEN	

Menopause if yes, What Age? ___________________

Date of last PAP Smear, If yes, was it normal? ______Yes ______No

Mammogram, if yes, was it normal? ______Yes ______No

Breast Implants _______ Any Miscarriages ______ Lumps in Breasts ________ Breast Pain _______

MEN ONLY

		NO		YES HAVE NOW		YES PAST	WHEN	
Impotence		NO		YES HAVE NOW		YES PAST	WHEN	
Unable to procreate		NO		YES HAVE NOW		YES PAST	WHEN	
Prostitis		NO		YES HAVE NOW		YES PAST	WHEN	

PERSONAL HISTORY

Do you now, or have you in the past had any of the following:

		NO		YES HAVE NOW		YES PAST	WHEN	
Migraine, headaches		NO		YES HAVE NOW		YES PAST	WHEN	
Epilepsy or convulsions		NO		YES HAVE NOW		YES PAST	WHEN	
Stroke		NO		YES HAVE NOW		YES PAST	WHEN	
Glaucoma		NO		YES HAVE NOW		YES PAST	WHEN	
Cataracts		NO		YES HAVE NOW		YES PAST	WHEN	
Ear infections		NO		YES HAVE NOW		YES PAST	WHEN	
Asthma		NO		YES HAVE NOW		YES PAST	WHEN	
Chronic Bronchitis		NO		YES HAVE NOW		YES PAST	WHEN	
Emphysema		NO		YES HAVE NOW		YES PAST	WHEN	
Tuberculosis		NO		YES HAVE NOW		YES PAST	WHEN	
Missed heart beats		NO		YES HAVE NOW		YES PAST	WHEN	
Heart murmur as an adult		NO		YES HAVE NOW		YES PAST	WHEN	
Abnormal ECG		NO		YES HAVE NOW		YES PAST	WHEN	
Enlarged heart		NO		YES HAVE NOW		YES PAST	WHEN	
Heart attack		NO		YES HAVE NOW		YES PAST	WHEN	
Rheumatic Fever		NO		YES HAVE NOW		YES PAST	WHEN	
Angina		NO		YES HAVE NOW		YES PAST	WHEN	
High blood pressure		NO		YES HAVE NOW		YES PAST	WHEN	
Low blood pressure		NO		YES HAVE NOW		YES PAST	WHEN	
Gall stones		NO		YES HAVE NOW		YES PAST	WHEN	
Hepatitis		NO		YES HAVE NOW		YES PAST	WHEN	
Cirrhosis of liver		NO		YES HAVE NOW		YES PAST	WHEN	
Fatty Liver		NO		YES HAVE NOW		YES PAST	WHEN	
Enlarged Liver		NO		YES HAVE NOW		YES PAST	WHEN	
Stomach or duodenal ulcer		NO		YES HAVE NOW		YES PAST	WHEN	
Colon or bowel trouble		NO		YES HAVE NOW		YES PAST	WHEN	
Rectal trouble		NO		YES HAVE NOW		YES PAST	WHEN	
Hemorrhoids or piles		NO		YES HAVE NOW		YES PAST	WHEN	
Kidney or bladder infection		NO		YES HAVE NOW		YES PAST	WHEN	
Kidney stones		NO		YES HAVE NOW		YES PAST	WHEN	
Other kidney disease		NO		YES HAVE NOW		YES PAST	WHEN	
What								

	NO		YES HAVE NOW		YES PAST	WHEN	

Condition								
Poor blood clotting								
Diabetes		NO		YES				
On insulin		NO		YES				
How much								
Gout		NO		YES HAVE NOW		YES PAST	WHEN	
Hyper thyroid		NO		YES HAVE NOW		YES PAST	WHEN	
Hypo thyroid		NO		YES HAVE NOW		YES PAST	WHEN	
Varicose Veins		NO		YES HAVE NOW		YES PAST	WHEN	
Arthritis		NO		YES HAVE NOW		YES PAST	WHEN	
Polio		NO		YES HAVE NOW		YES PAST	WHEN	
Anger		NO		YES HAVE NOW		YES PAST	WHEN	
Anxiety		NO		YES HAVE NOW		YES PAST	WHEN	
Irritability		NO		YES HAVE NOW		YES PAST	WHEN	
Poor memory		NO		YES HAVE NOW		YES PAST	WHEN	
Drug Allergy		NO		YES HAVE NOW		YES PAST	WHEN	

If yes,
name of the drug ______________________________

MEDICINES

Please list all prescription medicines or drugs you are now taking what were prescribed by a doctor or dentist. (Include what you take for chronic conditions, birth control, etc.)

Name	Dose	Frequency	How Long

NON-PRESCRIPTION

Please list medicines and drugs you sometimes take that were bought WITHOUT a PRESCRIPTION (such as aspirin, antacids, sleep medicine, allergy, cold medicine, etc.)

Name	Dose	Frequency	How Long

NUTRITIONAL SUPPLEMENTS

Please list all vitamins, minerals and/or nutritional supplements that you are now taking. Please indicate strength and number taken daily.

Name	Dose	Frequency	How Long