Integrated Health Solutions, LLC
Synergy • Optimism • Understanding • Love

Male Client History Form

Client Name:____Date:____________
Birthdate: ________________________________ Age:________ Gender: F______M______
Address:____
City____State________ Zipcode_________________
e-mail:____
phone # home:________________________**cell:**________________________**work:**_________________

Thermogram Hx:
type: initial ROI scan_____ follow-up ROI scan_____ initial fullbody scan_____
follow-up fullbody_________last thermogram date: ___________
total # previous scans: (prior to appointment today) ___________
I am requesting that my thermography results be sent to my healthcare provider: Yes_____ No______
My provider's name, address, and phone number is:____
____
Client Signature:____**Date**______________

Male History:

Please answer questions below by placing a check mark in the yes or no column →	yes	no
1. Have you had an annual **physical examination by a doctor?**		
2. Have you had a prostate exam? **last exam:**______________ **normal: yes**_____ **no**_____		
3. Have you had your PSA tested? **lab value:**______________ **normal: yes**_____ **no**_____		
4. How many **children** do you have?_______ How old were you when your first child was born?_________		
5. other:		

Have your had any past surgeries:

- □ any kind of surgery____________________________________What year?____________
- □ any kind of surgery:___________________________________What year?____________
- □ any kind of surgery:___________________________________What year?____________
- □ any kind of surgery:__________________________________ __What year?____________

Other client history:

Please answer questions below by placing a check mark in the hes or no column →	yes	no
1. Do you currently smoke □ **never** □ **current smoker** **How many years total did you smoke?**_______ **How long since you stopped smoking?** □ **<12 months** □ **> 5 yrs** □ **>10 yrs** □ **> 20 yrs**		
2. Allergies:□ food □ environmental □ meds (describe):		
3. other:		

Comments:____
____
____

Name____**date:**____________

Current medications/supplements:

Current Prescribed Medications (include # of months or years on medication):

□ ______________________________#yrs:__-#mo__ □ ______________________________-#yrs:__-#mo__
□ ______________________________#yrs:__-#mo__ □ ______________________________-#yrs:__-#mo__
□ ______________________________#yrs:__-#mo__ □ ______________________________-#yrs:__-#mo__

Current Supplements (include # of months or years on supplementation):

□ ______________________________#yrs:__-#mo__ □______________________________#yrs:__#mo__
□ ______________________________#yrs:__-#mo__ □______________________________#yrs:__#mo__
□ ______________________________#yrs:__#mo__ □______________________________#yrs:__ #mo__

Current Symptoms: **please check all that apply:**

General Symptoms	**Ears, Nose, Throat, Mouth**	**Genital/Urinary Tract:**
□ tires easily, fatigue □ weight increase □ weight loss (unintentional) □ night sweats □ sensitivity to heat □ sensitivity to cold □ excessive thirst □ other______________________ ______________________________	□ ringing in ears R___L___ □ loss of hearing R___L___ □ loss of smell □ postnasal drip □ sinus congestion □ chronic cough □ dry, sore throat □ sore gums □ other____________________	□ excessive urination, frequency □ pain with urination □ decreased force of urine stream □ irregular menstrual periods □ excessive menstrual bleeding □other_______________________ ______________________________ ______________________________ ______________________________
CardioRespiratory: □ persistent cough □ sputum production (phlegm) □ wheezing □ chest pain □ shortness of breath □ trouble-breathing lying down □ palpitations □ other _____________________	**Digestive Symptoms:** □ nausea □ constipation □ diarrhea □ excessive gas, bloating □ heartburn (acid stomach) □ difficulty swallowing □ change in appetite □ other_____________________	**Psychoemotional:** □ depression □ irritiability □ lack of sex drive/desire □ change in personality □ mood swings □other_______________________ ______________________________ ______________________________
Musculoskeletal: □ muscle cramps □ muscle weakness □ joint pain □ joint stiffness □ swollen joints □ sprained/broken bones □ **describe body part/s affected:** ______________________________	**Nervous System:** □ insomnia □ headaches □ dizziness □ memory loss □ loss of coordination □ other______________________ ______________________________ ______________________________	**Comments:**_________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

Name____**date:**_____________

Diagnoses/clinical concerns:

Please answer questions below by placing a check mark in the yes or no column →			yes	no
1. **Have you ever been diagnosed with prostate cancer? month/year diagnosed? _______ How was the cancer detected?** □ self exam □ clinical exam □ thermogram □ ultrasound				
2. Do you have any of the following **(briefly describe)**? **how long?**	**# mo**	**# yrs**	**yes**	**no**
other cancer (type):___________________________________				
thyroid problems:				
blood sugar problems:				
hormone imbalance:				
gallbladder disturbances:				
migraines/frequent headaches:				
sleep disturbance/insomnia:				
chronic fatigue/fibromyalgia:				
chronic pain/injury:				
arthritis:				
osteopenia.osteoporosis:				
adrenal fatigue/chronic stress:				
kidney concerns				
dental problems (left upper___left lower___right upper___right lower___)				
chronic sinusitis:				
gastrointestinal disturbance:				
heart concerns:				
hypertension:				
lung disease (type):____				
liver dysfunction:				
other:				

Name:____ Today's date________________ IHS client Hx

Family History

Family Health Status: *(check all that apply)	deceased (yes)	breast cancer (yes)	prostate cancer (yes)	other cancer (yes)	cancer type (describe)	heart disease (yes)	high BP (yes)	stroke (yes)	obesity (yes)	diabetes (yes)	thyroid problem (yes)
Mother											
Father											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Sibling (gender) F____M____											
Sibling (gender) F____M____											
Sibling (gender) F____M____											
Sibling (gender) F____M____											
Sibling (gender) F____M____											
Child (gender) F____M____											
Child (gender) F____M____											
Child (gender) F____M____											
Child (gender) F____M____											
Maternal Aunt											
Maternal Aunt											
Maternal Uncle											
Maternal Uncle											
Maternal Cousin											
Maternal Cousin											
Paternal Aunt											
Paternal Aunt											
Paternal Uncle											
Paternal Uncle											
Paternal Cousin											
Paternal Cousin											

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Medical Disclaimer Agreement

Integrated Health Solutions was created to provide personalized approaches to health and optimal wellness by bridging conventional medical healthcare with holistic programs. The intent is that IHS providers will partner with our clients to design a comprehensive package of assessment and healing for those seeking wholeness and health.

If you wish to treat a specific disease or condition you should consult with a licensed medical physician. Integrated Health Solutions will not be liable for any direct, indirect, consequential, special, exemplary, or other damages arising there from.

____
Print Name

________________________________ ____________________
Signature Date

________________________________ ____________________
Witness Date

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Shared Information Agreement

Integrated Health Solutions was created to provide personalized approaches to health and optimal wellness by bridging conventional medical healthcare with holistic programs. The intent is that IHS providers will partner with our clients to design a comprehensive package of assessment and healing for those seeking wholeness and health.

To ensure the maximum knowledge and creative potential of the IHS practitioners, it is essential to share all of their insights from their assessment and healing approaches with the client. This means that there will be one file that all practitioners can access and put information into and it also means dialogue will take place.

IHS is committed to working with the clients' doctor and sharing all information. This means the doctor will share his/her findings and lab and x-ray reports with IHS and vice versa.

I, ______________________________________ agree that IHS may share all clinical findings with each other and with my physician, Dr. ____________________________. I also agree that my physician may share all his/her clinical findings with IHS practitioners. I would like IHS to exchange and share all clinical information with the following practitioners, who are also involved in my care planning.

1.______________________________ 2.________________________________

3.______________________________ 4.________________________________

____
Print Name

_______________________________ ____________________
Signature Date

_______________________________ ____________________
Witness Date