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

New Client Female History

7606 N. Union Blvd. Ste. A
Colorado Springs, Colorado 80920
phone: 719-573-2254

Client Name: ____Date:___________
Birthdate: ____________________ Age:________ Gender: F_____ M_____
Address:____
Email:____
Phone # home:____________________cell:______________________work:____________________

Thermogram Hx:
Type: initial breast scan_____ follow-up breast scan_____ initial fullbody scan_____ follow-up fullbody_____
I am requesting that my thermography results be sent to my healthcare provider: Yes_____ No______
My provider's name, address, and phone number is:____
____
I understand that breast cancer risk is best evaluated by determining possible change over time of my thermographic findings. Therefore, I will need a follow-up breast scan within 3-6 months of my initial scan to obtain my baseline reading. Thereafter, my follow-up scans need to be done annually, or sooner, based on physician interpretation of the physiologic stability of my scans. All thermography findings require clinical evaluation and interpretation by qualified healthcare practitioners.

Client Signature:____Date____________

Mammogram Hx:

Please answer questions below by placing a check mark in the yes or no column →	**yes**	**no**
1. Have you had a mammogram in the past 12 months Last mammogram date: __________		
2. Have you had a mammogram in the past 5 years Last mammogram date: __________ **How many mammograms have you had?________ beginning at what age?________**		
3. Have you had any **abnormal findings with any mammograms** or other breast evaluation? If yes, describe:		

Female History:

Please answer questions below by placing a check mark in the yes or no column →	**yes**	**no**
1. Did your periods **(menses) begin** before age 12		
2. Did your periods **(menses) finish** after age 50		
3. Have you ever been diagnosed with **breast conditions : □ fibrocystic, □ cystic, □ mastitis**		
4. Have you taken **birth control pills** for more than 1 year How many years?____________ How long ago?________________		
5. Have you taken **hormone replacement therapy** How long?____________ what kind?____		
6. Have you had cancer of the uterus (womb)		
7. **Last PAP was normal:**		
8. Do you perform a monthly **breast self exam**		
9. Have you had an annual **physical examination by a doctor**		
10. How many **children** do you have?_______		

How old were you when your first child was born?__________		
11. other		

Name____**date:**____________

Please answer questions below (place a check mark in Yes or No column →			**yes**	**no**
Do you have any of the following CLINICAL CONCERNS ? **(Briefly describe and/or check the appropriate information)? How Long?**	**# mo**	**# yrs**		
Cancer (type):___________________________________ Date Dx:____________________ Lymph nodes +_________ Surgery:__________ Chemotherapy:__________ Radiation:_________				
thyroid problems:				
blood sugar problems:				
hormone imbalance:				
perimenopause/menopause:				
migraines/frequent headaches:				
sleep disturbance/insomnia:				
fibromyalgia/chronic fatigue: Hx of anemia? Describe:____				
chronic pain/injury: Location:____________________________________				
arthritis: Location:____				
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:				
gallbladder disturbances:				
other:				

Name____**date:**_____________

Surgical history:

Please answer questions below by placing a check mark in the yes or no column →	yes	no
1.. Have you had any **biopsies or surgeries** due to abnormal breast findings What month/year?___________ Results were: _____positive _____negative Select specific area of breast involved: □ above left breast □ above right breast □ left upper outer breast □ right upper outer breast □ left lower outer breast □ right lower outer breast □ left breast at nipple □ right breast at nipple □ left upper inner breast □ right upper inner breast □ left lower inner breast □ right lower inner breast □ under left breast □ under right breast **Biopsy Results**: **Non-estrogen +_____ estrogen +_____ progesterone +_____ Her2____**		
2. Have you had a **lumpectomy**? What month/year?__________________ Select specific area of breast involved: □ above left breast □ above right breast □ left upper outer breast □ right upper outer breast □ left lower outer breast □ right lower outer breast □ left breast at nipple □ right breast at nipple □ left upper inner breast □ right upper inner breast □ left lower inner breast □ right lower inner breast □ under left breast □ under right breast **Did you have clean margins? _____yes _____no**		
3. Did you have **lymph nodes removed**? Sentinel node_____ total # removed_______ Right axilla______ Left axilla______ Total # lymph nodes positive:____________		
4. Have you had a **mastectomy**? Left breast____ Right breast_____ Date(mo/yr):________ Did you have clean margins? _____yes _____no		
5. Have you had **additional breast surgery for cancer recurrence**? Date(mo/yr):_______ Location/comments:		
6. Have you had breast **cosmetic surgery or implants**? What year?_________		

Have your had any of the following past surgeries:

- □ partial hysterectomy (ovaries remain) What year?___________
- □ total hysterectomy (both ovaries and uterus removed) What year?__________
- □ Any other kind of surgery:________________________________ What year?______
- □ Any other 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:		

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____
□ ____________________________#yrs:____ #mo____□ ____________________________#yrs:____ #mo____

Current Symptoms: please check all that apply:

General Symptoms
□ tires easily, fatigue
□ weight increase
□ weight loss (unintentional)
□ night sweats
□ sensitivity to heat
□ sensitivity to cold
□ excessive thirst
□ other______________________
____

Ears, Nose, Throat, Mouth
□ 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____________________

Breast symptoms: □ **none**
□ pain R___L___
□ tenderness R___L___
□ lumps R___L___
□ change in breast size R___L___
□ thickening or dimpling R___L___
□ nipple secretions R___L___
□ other________________________
____

Day of menstrual cycle today________
Last mammogram date: ________
Last mammogram findings:
□ **negative** □ other studies required

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____________________

Genital/Urinary Tract:
□ excessive urination, frequency
□ pain with urination
□ decreased force of urine stream
□ irregular menstrual periods
□ excessive menstrual bleeding
□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_____________________
____
____

Psychoemotional:
□ depression
□ irritiability
□ lack of sex drive/desire
□ change in personality
□ mood swings
□ other________________________
____

Comments:____
____
____
____

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											

Medical Disclaimer Agreement

Integrated Health Solutions was created to provide personalized approaches to health and optimal wellness by complimenting conventional medical healthcare with holistic programs. The intent is that IHS providers will partner with our clients, and their chosen healthcare providers, to support their healthcare goals.

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 Client Name	Print Witness Name
______________________________	______________________________
Client Signature	Witness Signature
____________________	____________________
Date	Date

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

I, _______________________________________ agree that IHS clinicians may share all clinical findings with one another as it pertains to my healthcare, 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