Integrated Health Solutions, LLC
Synergy • Optimism • Understanding • Love
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New Client Female History

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											

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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

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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. 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