Helping You Live A Better Life

Saylor Medical Group, Inc.

GENERAL INFORMATION:

Name _____ **Date** _____

Address_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **SS#**_____ [ ]Married [ ]Single [ ]Partner [ ]Divorced [ ]Widowed

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Email_____ **Occupation**_____

May we contact you by Email [ ]YES [ ]NO Would you like to receive our Health E-Newsletter [ ]YES [ ]NO

Emergency Contact_____ **Referred by**_____

Primary Physician_____ **Contact #**_____ **May we contact them [ ]Yes [ ]No**

Have you had Functional Medicine (Acupuncture, Herbal, Homeopathy, Other) Before? [ ]Yes [ ]No

Are you presently under a doctor's care? [ ]Yes [ ]No

Who and for what?_____

Are there any other therapies which you are receiving?_____

With who and for what?_____

_____

FOCUS:

What is your primary reason for seeking care at our office?_____

What was the initial cause?_____

When did it begin?_____

What makes it worse?_____

What makes it better?_____

How does this problem interfere with your daily activities? [ ] Work [ ] Standing [ ] Sexually
[ ] Sleep [ ] Emotional [ ] Recreation [ ] Walking [ ] Relationships
[ ] Standing [ ] Sitting [ ] Social Life [ ] Stretching
[ ] Other_____

What have you done about this?_____

Are you interested in (check as many as apply)

[ ] Reduce body fat	[ ] Weight Loss	[ ] Increase muscle mass
[ ] Increase energy levels	[ ] Elevate mood	[ ] Better sleep
[ ] Strengthen immune system	[ ] Improve cognition	[ ] Stress Relief
[ ] Enhance sexual performance and desire	[ ] Lower cholesterol & blood pressure	
[ ] Pain Relief	[ ] Performance Care	[ ] Maintenance Care
[ ] Preventative Care	[ ] Holistic Health	[ ] Oriental Nutrition
[ ] Herbal Therapy	[ ] Homeopathy	[ ] Anti-Aging
[ ] Longevity	[ ] Esthetic/Cosmetic Medicine	[ ] Other_____

What are your health goals?_____

_____

SOCIAL HISTORY

Employed: job title or description: _____

[ ] Retired **[ ]** Disabled

HABITS		**EXERCISE**	**STRESS**	**SLEEP**
[ ] Smoking	Packs/Day_____	**[ ]** None	**[ ]** None	**[ ]** Good
[ ] Alcohol	Drinks/Day_____	**[ ]** Moderate	**[ ]** Moderate	**[ ]** Poor
[ ] Coffee	Cups/Day_____	**[ ]** Daily	**[ ]** Extreme	
		Type_____		

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Allergies
Mother	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Father	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Brother, #_____	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**
Sister, #_____	**[ ]**	**[ ]**	**[ ]**	**[ ]**	**[ ]**

Other:_____

_____

PAST MEDICAL HISTORY

Accident history: (Dates and outcome of accidents)

_____

_____

_____

_____

Medical history: (any illness or condition(s) you have been diagnosed with)

_____

_____

_____

_____

Surgical history: (surgeries and dates)

_____

_____

_____

_____

Medications: (medications and dosage you are currently taking)

_____

_____

_____

_____

Supplements: (any supplements you are taking)

_____

_____

_____

Allergies: (any allergies you have)

_____

_____

Please mark each item below for each sign or symptom if you presently have or previously had:

GENERAL SYMPTOMS
[ ] Convulsions
[ ] Dizziness
[ ] Fainting
[ ] Headache
[ ] Nervousness
[ ] Numbness
[ ] Wheezing

EYE/EAR/NOSE/THROAT
[ ] Earache
[ ] Ear Noises
[ ] Tonsillitis
[ ] Enlarged Thyroid
[ ] Frequent Colds
[ ] Hay Fever
[ ] Nasal Blockage
[ ] Pain in Eyes
[ ] Poor Vision
[ ] Sinusitis
[ ] Sore Throats

GENITO-URINARY
[ ] Bladder Trouble
[ ] Blood in Urine
[ ] Frequent Urination
[ ] Kidney Infection
[ ] Painful Urination
[ ] Prostate Trouble

FOR WOMEN ONLY
Pregnant at this Time
[ ] Yes [ ] No
[ ] Cramps/Backaches
[ ] Hot Flashes
[ ] Excessive Flow
[ ] Irregular Cycle
[ ] Miscarriage
[ ] Painful Periods
[ ] Vaginal Discharge
[ ] Breast Pain

MUSCLES & JOINTS
[ ] Low Back Problems
[ ] Pain between Shoulders
[ ] Neck Problems
[ ] Arm Problems
[ ] Leg Problems
[ ] Swollen Joints
[ ] Painful Joints
[ ] Stiff Joints
[ ] Sore Muscles
[ ] Weak Muscles
[ ] Walking Problems
[ ] Ruptures
[ ] Broken Bones

GASTRO-INTESTINAL
[ ] Excessive Hunger
[ ] Belching/Gas
[ ] Colon Trouble
[ ] Constipation
[ ] Diarrhea
[ ] Excessive Thirst
[ ] Liver Trouble
[ ] Gall Bladder Trouble
[ ] Hemorrhoids
[ ] Pain over Stomach
[ ] Nausea
[ ] Poor Digestion
[ ] Vomiting
[ ] Vomiting Blood
[ ] Black Stool
[ ] Bloody Stool
[ ] Weight Trouble

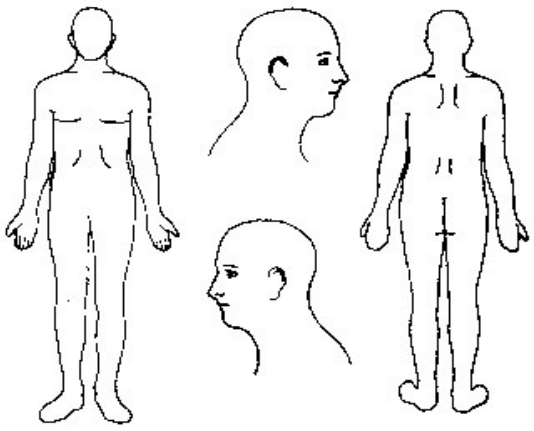
CARDIO-VASCULAR
[ ] Blood Pressure Problems
[ ] Pain over Heart
[ ] Poor Circulation
[ ] Heart Trouble
[ ] Rapid Heart
[ ] Slow Heart
[ ] Strokes
[ ] Swelling Ankles
[ ] Varicose Veins
[ ] Palpitations

RESPIRATORY
[ ] Nose Bleeds
[ ] Asthma
[ ] Chronic Cough
[ ] Difficulty Breathing
[ ] Spitting Blood
[ ] Spitting Phlegm

SKIN OR ALLERGIES
[ ] Boils
[ ] Bruising Easily
[ ] Dryness
[ ] Eczema
[ ] Hives
[ ] Itching
[ ] Sensitive Skin
[ ] Allergy (what) _____
_____

OTHER:_____
_____
_____

For Pain Complaints -- Please Mark The Areas Of Pain



AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account or receipt. However, **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment**. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate and I give authority for any and all procedures to be performed for examination and treatment. It is understood and agreed that all records are and will remain the property of this office. These records are available where merited by Florida law for the copying charges as set forth by Florida law. I understand and accept that a 72 hour lead time is required for making records available (not including weekends, holidays or posted office closings). **The patient also agrees that he/she is responsible for any and all bills incurred at this office.** The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I acknowledge and accept there is no implied or given warranty of success for any treatment, supplement or product.

I understand that this agreement does not void any other agreement(s) I have entered into with Saylor Medical Group, Inc., including those for payment or financing or those with any company providing medical, supply or financial services to Saylor Medical Group, Inc.

I give permission for Saylor Medical Group to leave
Appoinment Information _____ and/or Medical Information _____
on answering machine at _____
or by email at the address listed on page one.

The above appointment / medical information may be given to _____.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE **DATE**

INTEGRATIVE FUNCTIONAL MEDICINE
SAYLOR MEDICAL GROUP