



Clifton Springs Hospital & Clinic  
 2 Coulter Road  
 Clifton Springs, NY 14432

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**The Springs Integrative Medicine Center and Spa**

**Health History Intake Form**

Today's date: \_\_\_\_\_

Name (Last): \_\_\_\_\_ (MI): \_\_\_\_\_ (First): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: HOME ( ) \_\_\_\_\_ WORK ( ) \_\_\_\_\_ CELL ( ) \_\_\_\_\_

*Do we have permission to leave a message on answering machine or voicemail?*

*Please mark any that you give permission for:* HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

Parent Or Guardian (For Minor Patient): \_\_\_\_\_

Name Of Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

*If you would like to receive emails from The Springs to receive information about educational programs, news, articles, or special promotions, please provide your email address. You may choose to unsubscribe at any time and your email will never be sold or shared with any other list.*

EMAIL: \_\_\_\_\_

**Please complete this 2-sided questionnaire as thoroughly as possible. This is a confidential record of your medical history and will not be released except when you authorize us to do so or if required by law.**

**Please List Medications That You Are Currently Taking, With Dosages:** (Please include prescription and non-prescription drugs. Ex: allergy medications, aspirin, Tylenol, Advil, laxatives, oral contraceptives, hormones etc.)

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |
| 7) _____ | 8) _____ |

**Do you use Retin-A for skin conditions?**  YES  NO

**List vitamins, minerals, herbs, and/or homeopathic remedies presently taking, with dosages:**

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |
| 7) _____ | 8) _____ |

**Please list any known allergies to the following: (Explain the reactions)**

Drugs: \_\_\_\_\_

Foods (include gluten, nuts, seafood, iodine, etc.): \_\_\_\_\_

Environmental (grasses, pollens, animal dander, etc.): \_\_\_\_\_

**What goals do you have for your visit today?**

Primary goal: \_\_\_\_\_

Other goals: \_\_\_\_\_

For WOMEN, are you pregnant or trying to become pregnant?  YES  NO If Yes, # \_\_\_\_\_ weeks gestation.



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**The Springs Integrative Medicine Center and Spa**

**Please mark any conditions that you have now or have had in the last year:**

**HEAD SYMPTOMS**

- Headache  
TYPE:  Migraine  
 Sinus  
 Tension
- Loss of memory
- Light-headedness
- Dizziness / vertigo
- Fainting
- Loss of balance

**NECK**

- Pain in neck
- Stiff neck
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasm in neck
- Loss of Range of Motion
- Bone spurs in neck
- Arthritis in neck
- Whiplash (date) \_\_\_/\_\_\_/\_\_\_
- Any neck SURGERY:  
Explain: \_\_\_\_\_  
\_\_\_\_\_

**EARS**

- Loss of hearing
- Do you wear hearing aids? \_\_\_
- Pain in ears
- Ringing in ears

**CARDIO/RESPIRATORY**

- Chest pain
- High blood pressure
- Low blood pressure
- Swelling in ankles
- Chronic cough
- Pacemaker
- Congestive Heart Failure
- Coumadin, Warfarin, etc.
- Stroke
- Blood clots / embolism

**MID-BACK**

- Mid- Back pain
- Pain btw. shoulder blades
- Sharp stabbing pain
- Muscle Spasm
- Arthritis in back
- Scoliosis

**LOW BACK**

- Low back pain
- Pinched nerve in low back
- Low back feels out of place
- Muscle spasm
- Arthritis
- Sciatica

Describe your low back pain:

- Throbbing  Stabbing
- Sharp  Aching
- Burning  Electrical

Does your pain radiate? \_\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had back SURGERY:

Explain: \_\_\_\_\_  
\_\_\_\_\_

Herniated Discs? \_\_\_\_\_  
\_\_\_\_\_

**OTHER ORGAN SYSTEMS**

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Vomiting
- Frequent urination
- Dermatitis/Excema
- Psoriasis
- Other Skin Condition:  
\_\_\_\_\_

**SHOULDERS**

- Pain in shoulder joint
- Pain in shoulder muscle
- Bursitis: Right / Left
- Arthritis: Right / Left
- Can't raise arm  
 above shoulder level  
 over head
- Tension in shoulders
- Pinched nerve - shoulder
- Muscle spasms - shoulder
- Radiating pain down arm
- Throbbing pain in elbow or back of arm

**ARMS & HANDS**

- Pain-upper arm: Right / L
- Pain-forearm: Right / Left
- Pain-hands: Right / Left
- Pain-fingers: Right / Left
- Numbness/Tingling  
 WRIST: Right / Left  
 FINGERS: Right / Left
- Hands cold: Right / Left
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Carpal Tunnel

**HIPS, LEGS, & FEET**

- Pain in buttock
- Pain in hip joint
- Pain down leg
- Pain down both legs
- Leg cramps
- Pins/ needles in legs
- Numbness of feet
- Cramps in feet
- Swollen ankles
- Swollen feet R-L
- Painful joints in toes
- Varicose veins
- Recent blood clots
- Arthritis hip, knees, feet
- Phlebitis

**MENTAL/EMOTIONAL**

- Nervousness
- Irritable
- Fatigue
- Twitching
- Numbness
- Grief
- Tension / Stress
- Depression
- Anxiety
- Insomnia
- Claustrophobia
- Other: \_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU BEEN DIAGNOSED W/ THE FOLLOWING?**

- Diabetes
- Fibromyalgia
- Multiple Sclerosis
- Rheumatoid Arthritis  
Areas affected: \_\_\_\_\_
- Crohn's Disease
- Ulcerative Colitis
- Lupus
- ALS
- Muscular Dystrophy
- Scleroderma
- Cancer  
Type: \_\_\_\_\_  
When: \_\_\_\_\_  
Treatment: \_\_\_\_\_
- Lymph Nodes Removed?  
How many? \_\_\_\_\_  
Where? \_\_\_\_\_
- Communicable Disease
- Other: \_\_\_\_\_  
\_\_\_\_\_

History of Surgeries: \_\_\_\_\_

Recent Injuries? Please describe: \_\_\_\_\_

Please list any other medical conditions, symptoms, or situations that practitioner should be aware of prior to your treatment:  
\_\_\_\_\_

Are you currently receiving medical care?  YES  NO      May we contact your care provider?:  YES  NO

If YES, for what condition(s)? \_\_\_\_\_

Name & Contact information of physician: \_\_\_\_\_

If NO, when and where did you last receive medical health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

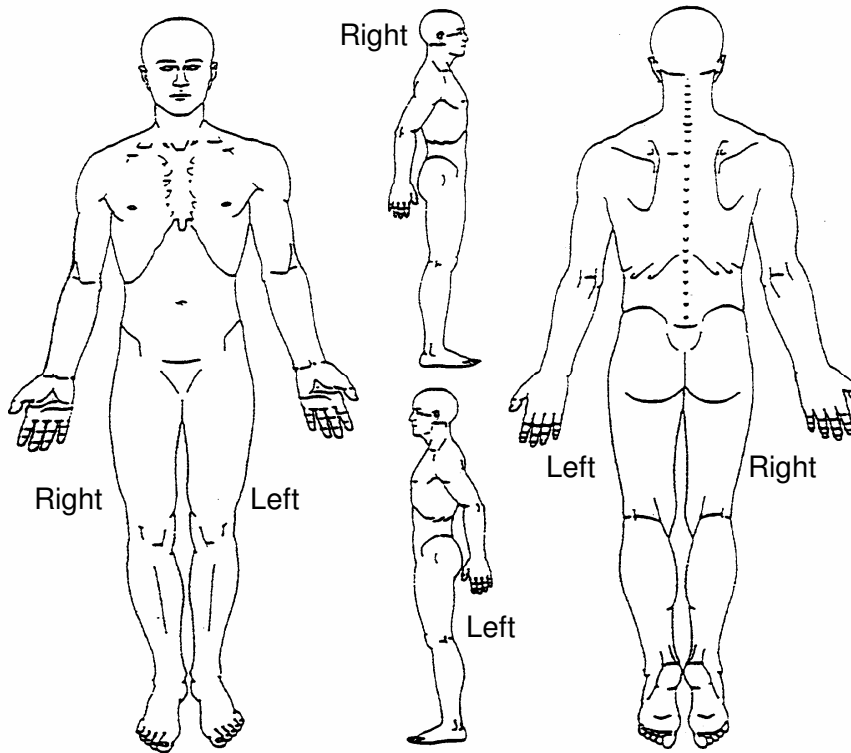


Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**The Springs Integrative Medicine Center and Spa**

**Please mark the areas you have pain, tension, or concerns:**



**Please circle the number below that represents your level of pain today.**

**No Pain      1      2      3      4      5      6      7      8      9      10      Worst Pain**

Have you received a professional massage before?       YES       NO

Have you received any esthetic/skincare/nail service before?       YES       NO

Have you had any problems or reactions to products before?       YES       NO

If yes, please explain: \_\_\_\_\_

The information I have provided is true and complete to the best of my knowledge. I agree to inform my practitioner of any changes in my health prior to treatment.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**The Springs Integrative Medicine Center and Spa**

**Consent for Treatment**

1. I hereby authorize the following treatments at The Springs Integrative Medicine Center & Spa at Clifton Springs Hospital & Clinic. You MUST initial each service you authorize.

\_\_\_\_\_ Massage Therapy                      \_\_\_\_\_ Hydrotherapy                      \_\_\_\_\_ Pedicure/Manicure  
\_\_\_\_\_ Facial Treatments                      \_\_\_\_\_ Body Wraps

2. The treatment(s) recommended to treat my condition, if applicable (has/have) been explained to me, and I understand the nature of the treatment(s) to be non-diagnostic in nature. These treatments do not take the place of medical care from a physician.
3. The benefits, risks and consequences that are associated with the treatment(s) have been explained to me. In addition, possible alternatives to the treatment(s) and risks of no treatment have been explained to me.
4. I understand the explanation of the risks and consequences I have received is not exhaustive and other, more remote, risks and consequences may arise. I have been advised that these more remote risks and consequences will be explained to me upon request. I acknowledge I have been given the opportunity to ask questions concerning this treatment(s), its risks and consequences, and my questions, if any, have been answered to my satisfaction.
5. I acknowledge I have informed my therapist of any medical conditions I have.
6. I acknowledge I have received no guarantee concerning the treatment(s) to which I am consenting.
7. I acknowledge I have read or have had this document explained to me in its entirety and I fully understand it.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

**If client is unable to sign or is a minor, complete the following:**

Check one:

- Patient is a minor \_\_\_\_\_ years of age.
- Patient is unable to understand benefits and/or risks of consenting or not consenting to treatment(s)

Parent or Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_

Signature of Authorized Individual \_\_\_\_\_ Date & Time \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The Springs Integrative Medicine Center and Spa

## Acknowledgement of Financial Policies

If you need to cancel or reschedule, your considerations of others seeking treatment in your place is greatly appreciated. **We will bill you for no show appointments or canceling with less than 24 hours notice.**

**By signing below, I acknowledge that I understand the following policies:**

- I will be charged the normal fee for treatment if I miss an appointment without canceling or if I cancel with less than 24 hours notice. Missed appointments for chiropractic are charged \$25. Insurance benefits will not pay for missed visits.
- I will be charged \$15 for returned checks.
- Payment is due at the time of treatment. Discounts or coupons may be refused if I do not provide FULL payment at the time of treatment.
- I will be responsible for full payment for my service, even if I am late for my appointment. It is my responsibility to arrive on time.
- I agree to keep my account balance current by paying at each visit. I understand that I may pay by cash, check or any major credit card, or by gift card for approved services.
- Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current.

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

### For Services covered by INSURANCE only:

- I authorize my insurance benefits be paid directly to my practitioner or representatives. I am financially responsible for any unpaid balance due.
- Unpaid insurance claims over 60 days become the responsibility of the patient, and must be paid in full by the patient.
- I fully understand that insurance policies are arrangements between my insurance company and myself, and that billing done by this office is a courtesy. I am ultimately responsible for any expenses not paid by my insurance company, and I assume responsibility for keeping my account current. I hereby authorize the release of any information requested by my insurance company needed in the process of treatment verification, claim eligibility, and payment authorization.

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time