

Alternative Strategies In Healing 5951 Wilson Mills Rd. Highland Hts. Ohio 44143

Office: 440-684-0091, Cell: 216-219-0469, Email:michael@drmichaelfrost.com

WWW.drmichaelfrost.com

PLEASE PRINT

PERSONAL INFORMATION

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ SOC. SEC. NO. _____ DATE OF BIRTH _____
MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____
OCCUPATION _____ EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____
EMPLOYER _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____
ADDRESS _____ CITY/ZIP _____ TELEPHONE _____
REFERRED BY _____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$35 returned check charge in the event that my check is returned.

Date _____ Patient's Signature _____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Alternative Strategies in Healing to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date _____ Patient's Signature _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT _____

HOW DID IT HAPPEN? _____

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

TYPE OF TREATMENT _____ RESULTS _____

Habits

- Alcohol: Type _____
Amount _____
Diet: Salt intake _____
Fat intake _____
Other _____
- Sleep: Difficulty falling asleep _____
- Continuity disturbances _____
Early morning awakenings _____
Daytime drowsiness _____
Other _____
- Smoking: Packs daily _____
How long _____
Interested in stopping? _____
- Exercise routine: _____
- Caffeine: Coffee, cups daily _____
Other _____

MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

- RINGING IN EAR _____
 - EAR INFECTIONS - FREQUENT _____
 - DIZZINESS/FAINTING _____
 - FAILING VISION _____
 - EYE INFECTIONS _____
 - NOSE BLEEDS _____
 - SINUS TROUBLE _____
 - SORE THROATS - FREQUENT _____
 - HAYFEVER/ALLERGIES _____
 - PNEUMONIA _____
 - BRONCHITIS/CHRONIC COUGH _____
 - ASTHMA/WHEEZING _____
 - CHEST PAIN _____
 - HIGH BLOOD PRESSURE _____
 - HEART MURMUR _____
 - SWOLLEN ANKLES _____
 - LEG PAIN - WALKING _____
 - VARICOSE VEINS/PHLEBITIS _____
 - LOSS OF APPETITE _____
 - DIFFICULTY SWALLOWING _____
 - INDIGESTION OR HEARTBURN _____
 - PERSISTENT NAUSEA/VOMITING _____
 - PEPTIC ULCERS _____
 - ABDOMINAL PAIN - CHRONIC _____
 - GALL BLADDER TROUBLE _____
 - JAUNDICE/HEPATITIS _____
 - CHANGE IN BOWEL HABITS _____
 - DIARRHEA CONSTIPATION _____
 - DIVERTICULOSIS CROHN'S/COLITIS _____
 - BLOODY OR TARRY STOOLS _____
 - HEMORRHOIDS _____
 - HERNIA _____
 - URINE INFECTIONS - FREQUENT _____
 - BLOOD IN URINE _____
 - URINATION - OVERNIGHT > THAN TWICE
 PAINFUL LOSS OF CONTROL
 DECREASE IN FORCE/FLOW
 - KIDNEY STONES _____
 - VENEREAL DISEASE _____
 - URETHRAL DISCHARGE _____
 - CHRONIC FATIGUE _____
 - WEIGHT LOSS - RECENT _____
 - ANEMIA BRUISE EASILY _____
 - CANCER _____
 - DIABETES _____
 - THYROID DISEASE _____
 - CONVULSIONS/SEIZURES _____
 - STROKE _____
 - TREMOR/HANDS SHAKING _____
 - MUSCLE WEAKNESS _____
 - NUMBNESS/TINGLING SENSATIONS _____
 - HEADACHES - FREQUENT _____
 - ARTHRITIS/RHEUMATISM _____
 - OSTEOPOROSIS _____
 - BACK PAIN - RECURRENT _____
 - BONE FRACTURE/JOINT INJURY _____
 - GOUT _____
 - FOOT PAIN COLD NUMB FEET _____
 - RASHES HIVES _____
 - PSORIASIS ECZEMA _____
 - NERVOUSNESS DEPRESSION _____
 - MEMORY LOSS _____
 - MOODINESS - EXCESSIVE _____
 - PHOBIAS _____
 - MENTAL ILLNESS _____
 - LACTOSE INTOLERANCE _____
 - PROSTATE DISEASE _____
 - SEXUAL/MENSTRUAL DYSFUNCTION _____
 - FREQUENT INFECTIONS _____
 - DIPHTHERIA _____
 - TETANUS _____
 - CHICKEN POX POLIO MUMPS
 - MEASLES RUBELLA RHEUMATIC FEVER
 - SCARLET FEVER TUBERCULOSIS HERPES
 - OTHER _____
 - OTHER _____
- Females - Please Complete**
- PREGNANT? YES NO
- PLANNING PREGNANCY? YES NO
- Menstrual Flow:
 Regular Irregular Pain/Cramps
_____ Days of Flow _____ Length of Cycle
- Date-1st day of last period _____
- Pain/Bleeding during or after sex
- Number of:**
_____ Pregnancies _____ Abortions
_____ Miscarriages _____ Live Births
- Birth Control Method _____
- B.C. Pill (Name) _____
- Flushing/Menopause
- Date of Last PAP Test _____
- Normal Abnormal
- Date of Last Mammogram _____
- Normal Abnormal

HOSPITALIZATIONS:

| Date | Reason | Date | Reason |
|------|--------|------|--------|
| | | | |
| | | | |

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

| RELATIONSHIP | AGE IF LIVING | AGE AT DEATH | STATE OF HEALTH OR CAUSE OF DEATH | ILLNESS | FAMILY MEMBER |
|----------------------|---------------|--------------|-----------------------------------|---------------------|---------------|
| FATHER | | | | DIABETES | |
| MOTHER | | | | CANCER | |
| BROTHERS AND SISTERS | | | | BLOOD DISEASE | |
| | | | | GLAUCOMA | |
| | | | | EPILEPSY | |
| SPOUSE | | | | RHEUMATOID | |
| | | | | ARTHRITIS | |
| CHILDREN | | | | TUBERCULOSIS | |
| | | | | GOUT | |
| | | | | HIGH BLOOD PRESSURE | |
| | | | | HEART DISEASE | |
| | | | | BACK PROBLEMS | |