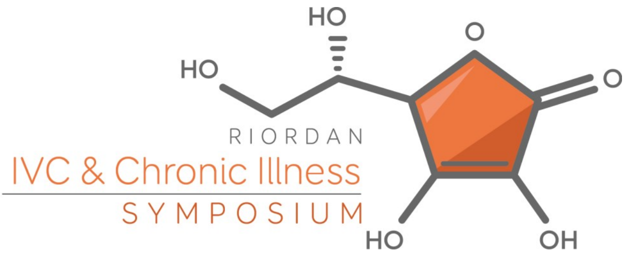

Care For The Providers

(Health History Form -required)

"Never order any therapy that you haven't first tried on yourself."
- Dr. Hugh Riordan

Name: ____ **Date:** ____________________

Primary Care Physician: ____

Weight: _______ lbs. **Height:** _________in. **Date of Birth:** ________ **Blood Pressure:** ____________

Therapies interested in:

Ordering Doctor: ____

CHIEF COMPLAINT:

____

____

____

HISTORY OF PRESENT ILLNESS:

____

____

____

ALLERGIES: (medication and reaction)

____

____

____

CURRENT MEDICATIONS: (Including vitamins, herbal remedies, homeopathic, over-the-counter, etc)

____

____

____

____

PAST MEDICAL HISTORY: (Pregnancy/perinatal history, medical, exposures, diet, transfusions)

____

____

____

PAST SURGICAL HISTORY:

____

____

____

FAMILY HISTORY: (Cardiac, cancer, respiratory, bleeding disorder, diabetes, high cholesterol)

____

____

____

SOCIAL HISTORY: (Current care taker, living situation, behavior-social adjustment)

____

____

____

REASON FOR SEEKING THERAPY: (Check all that apply)

- ☐ Seeking a personal lifestyle change towards better health.
- ☐ Interested in adding this to my practice.
- ☐ Wanting a better understanding of my patient's experience.
- ☐ Curious to see if I can feel better.
- ☐ I have always wanted to try this myself.
- ☐ Need a "pick me up" this weekend.

Please fax completed form to (316) 618-8537 or submit by email to onugraho@riordanclinic.org

"IVC First"