

Client Contact Information

MR# _____ (Office Use)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: _____

Phone: (day) _____ (evening) _____ (cell) _____

E-Mail Address: _____

(Email may be used for communication between patient and practitioner)

Do you wish to receive email newsletters from the Center? ___yes ___no

Place of Employment: _____

Address: _____

Telephone: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Primary Care Physician: _____

Health Insurance Company: _____ ID# _____

Referred By: Check One:

___friend; ___doctor; ___print ad; ___radio ad; ___internet search; ___tel book; ___walkby

STATEMENT REGARDING CRISIS MANAGEMENT and EMERGENCY MEDICAL CARE

As a CIHH client, I understand that the Center for Integrative Health and Healing does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis, I must obtain services that are appropriate to the type of crisis I am experiencing. If I am experiencing severe acute symptoms or a feel of life-threatening illness, I will call:

- 911
- My local hospital emergency room
- My local police or fire department
- Albany County Mobile Crisis Team 518-447-9650 (mental or emotional distress)

FINANCIAL AGREEMENT

As a CIHH client, I understand that I am responsible for the payment of services received through CIHH. I agree to keep my account current and will pay at the time of service unless I make some other arrangement.

I will notify the office 24 hours in advance if a cancellation is necessary.

Client Signature: _____ Date: _____

The Center for Integrative Health and Healing
Ronald L. Stram, MD, Director
388 Kenwood Ave, Delmar, NY 12054 Tel: (518-689-2244)/Fax:689-2081/www.cihh.net

Name: _____ MR# _____ (office use)

To provide the best possible healthcare, we the doctors need to completely understand the patient's physical, mental and emotional condition. By providing us with this information, we will be able to understand and assist you with your health needs and goals. Please print your answers to each question as completely as possible and either mark or leave blank any questions you are unsure of.

When did you last go to a doctor's office, medical clinic or hospital? _____

What was the reason? _____

What are your most important health concerns? _____

Please list any hospitalizations and surgeries you have had:

Do you have any allergies to foods, drugs, or other allergens in your environment (cats, mold, dust)? If yes, please explain: _____

Please mark any of the following that you are taking:

- | | |
|---|---|
| <input type="checkbox"/> Pain relievers (aspirin, Tylenol, ibuprofen) | <input type="checkbox"/> Diet Pills/Appetite suppressants |
| <input type="checkbox"/> Cortisone (cream or pills) | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Antacids (Rolaids, Tums) |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood pressure medication | <input type="checkbox"/> Heart medication |
| <input type="checkbox"/> Blood Thinner(coumidin, plavix, aspirin) | <input type="checkbox"/> Antidepressants |

Please list any specific medications or herbal supplements that you are currently taking:

Please mark if you or family members have experienced the following (please indicate which family member ie: self, mother, brother etc)

___ Cancer: _____

___ Diabetes: _____

___ Heart Disease: _____

___ Blood Pressure: _____

___ Mental Illness: _____

___ Lung Condition: _____

___ Allergies: _____

___ Other: _____

Please list issues you may have regarding each category or leave blank if not applicable:

Skin: _____

Head/Neck: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal: _____

Urinary: _____

Female Reproductive: _____

Male Reproductive: _____

Musculoskeletal: _____

Neurologic: _____

Psychiatric: _____

What are your main interests and hobbies? _____

Do you exercise? Yes No
How often? _____

What types of exercise? _____

Do you eat three meals a day? Yes No

Awake rested? Yes No

Sleep well? Yes No

Average hrs/night of sleep? _____

Spend time outside? Yes No

Take vacations? Yes No

Television - _____ hrs/day

Reading - _____ hrs/day

Use tobacco? Yes No

Use illegal drugs? Yes No

Have you ever been treated

For substance abuse or any kind?
(alcohol, drugs) Yes No

Weight _____

Weight 1yr ago _____

Maximum Weight _____

When? _____ Height _____

What is/are your support system(s)? _____

What is your occupation and do you enjoy it? _____

What are the major stresses in your life? _____

What do you do to relax/recreate/socialize/cope with stress? _____

When are you happiest, what gives you joy? _____

Client Signature: _____ Date: _____

Thank you for your effort. Welcome to The Center, we look forward to serving you!

CIHH Therapeutic Agreements

STATEMENT OF COLLABORATION

As a CIHH practitioner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of the people who I work with. I believe it is my responsibility to:

- Assess each person's situation based on the information they provide
- Assist them to sort through their health-related challenges
- Provide information and options about treatment modalities that are available
- Support them to make conscious decisions regarding their health
- Develop, implement and support a plan of care that will promote physical, mental and spiritual health
- Evaluate the effectiveness of a plan of care
- Make referrals to community resources as appropriate

As a CIHH client, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

- Provide my CIHH practitioner(s) with information that is relevant to my health
- Be willing to sort through my health-related challenges
- Ask questions related to treatment options and information that is provided
- If supplements are mutually agreed as part of my treatment plan, take them only according to directions given to me and discontinue use if side effects ensue and report this to my CIHH practitioner(s)
- Work together with my CIHH practitioner(s) to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and spiritual health
- Make conscious decisions to nurture intrinsic healing and promote balance in my life
- Evaluate the effectiveness of my plan of care
- Participate in all scheduled treatment sessions

CONFIDENTIALITY STATEMENT

As a CIHH client, I understand that what I discuss with my CIHH practitioner(s) will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release of information.

I understand that if my safety or the safety of someone else is at risk, my CIHH practitioner(s) are legally obligated to respond by sharing this information with the appropriate resources. For example:

- Licensed Social Workers, Nurses and Physicians are mandated by New York State Law to report any suspicion of child abuse to the New York State Registry
- Inform someone close to the client if they feel the client might harm him/herself or anyone else

CIHH practitioners believe that the concept of integrative medicine works best when CIHH practitioner discuss their work in team meetings, peer review, and/or supervision. This allows each client to benefit from the combined insight, knowledge, skill and experience of CIHH practitioners and those who supervise them. I understand that discussions of this nature would not include identifying information beyond a "need to know" basis, and such discussions would have the same privilege of confidentiality as sessions with each individual practitioner.

Client Signature: _____ Date: _____