Welcome! And thank you for choosing Tenpenny Integrative Medical Center as part of your journey to optimal health.

Financial Information:
Payment in full is due at the time of service. We accept cash, check, and most major credit cards.

While we do not participate with any insurance company directly, we do participate with CareCredit and most HSA plans. At the time of your visit, you will be given a HCFA form as a receipt for your services; you can submit this form to your insurance carrier for possible reimbursement. The amount of reimbursement will vary based on the amount of out-of-network coverage your plan provides and if you have met your out-of-network deductible. **HCFA FORMS CANNOT BE SUBMITTED TO MEDICARE OR MEDICAID.**

We do not participate with Medicare. We do not participate with Medicaid, CHIPS or military insurance programs.

Our goal is to identify the underlying cause(s) that lead to your current condition using unique testing and assessments. Many of our specialized tests are not covered by medical insurance. Most of the laboratories we use require a co-payment to be sent, with your blood samples, directly to the laboratory.

PLEASE ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT ***WITH YOUR FORMS COMPLETED.***

Completed forms are very important for your assessment. If the forms are not with you or are not completed prior to your scheduled appointment, it may be necessary to reschedule your appointment and enforce our cancellation policy to respect the time of other patients scheduled after your appointment.

HOW DID YOU HEAR ABOUT US?

Please help us know how to best reach others. Mark all that apply.

- ☐ Patient referral: ______
- ☐ Physicians referral: ______
- ☐ Tenpenny Integrative Medical Center website
- ☐ DrTenpenny.com website
- ☐ Other website ______
- ☐ Westlake Magazine
- ☐ Berea Community Guide
- ☐ Our eNewsletter
- ☐ Direct mail marketing piece
- ☐ Radio show ______
- ☐ TV show ______

Social Media Referral

- ☐ Facebook
- ☐ Twitter
- ☐ YouTube video
- ☐ Other: ______

WHO ARE YOU SEEING TODAY?

☐	Sherri Tenpenny, DO	☐	Matthew Grant, DC
☐	Janet Levatin, MD	☐	Sandi Asazawa, PA
☐	Autumn Schaef, NP	☐	Thermographer
☐	Blake Hardy, NP	☐	other ---

TENPENNY

INTEGRATIVE MEDICAL CENTER

7380 Engle Road
Middleburg Heights, Ohio 44130
440.239.3438
www.TenpennyIMC.com

CHIROPRACTIC HISTORY

Full name				DOB	
Address				Age	
				MALE	FEMALE
City	State	Zip		MARITAL STATUS	
HOME TELEPHONE:	WORK TELEPHONE:		MOBILE PHONE		
OCCUPATION:	EMERGENCY CONTACT AND NUMBER				

Is this a work related injury? NO YES

(if no, go to next page)

TYPE OF ACCIDENT: WORK AUTO

To whom have you made a report? Auto Insur. Employer B.W.C. Other

IF YES, are you working with an attorney? NO YES

IF YES, attorney name and contact information.

IF YES, please describe the accident, including date.

Types of treatments you have a had to date:

Date of last physical exam:

Date of last X-ray exams:
Cervical Thoracic Lumbar Chest Dental

Date of last MRI or CT scan:

CHIROPRACTIC HISTORY

Full name

Reason for Visit:

When did the symptoms first appear?

Is the condition getting progressively worse? YES NO UNSURE

Rate the severity of pain on a scale from 1 (least) to 10 (worst)

How often do you have this pain?

Is the pain constant, or does it come and go?

What does the pain interfere with: mark all that apply

	DAILY ROUTINE	WORK	EXERCISE	SITTING	SLEEPING	

Which activities are painful to perform? mark all that apply

	SITTING	STANDING	WALKING	BENDING	LYING DOWN	

Type of pain: Mark all that apply

	SHARP	DULL	THROBBING	NUMBNESS	ACHING	
	BURNING	TINGLING	CRAMPING	STIFFNESS	SHOOTING	

On the next page (body figures) please mark here you have pain, numbness, tingling, etc.

Types of treatments you have a had to date:

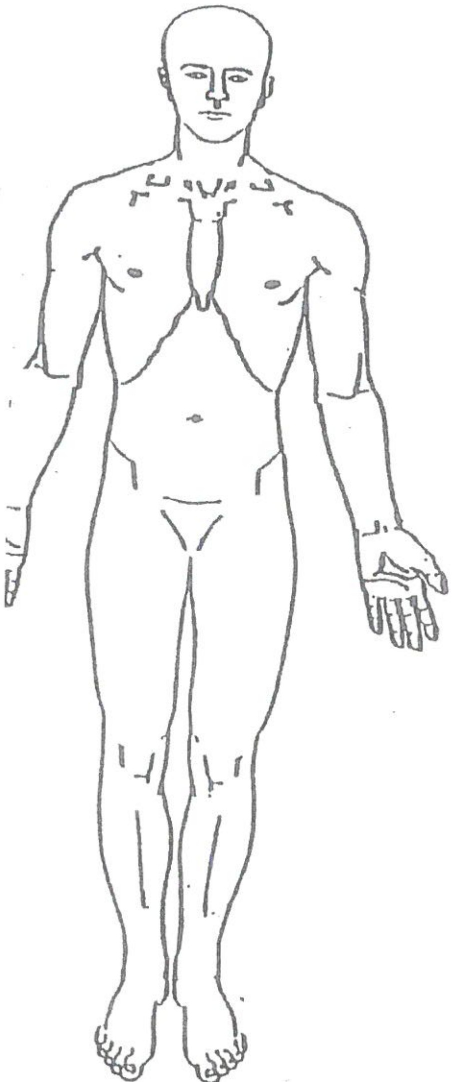
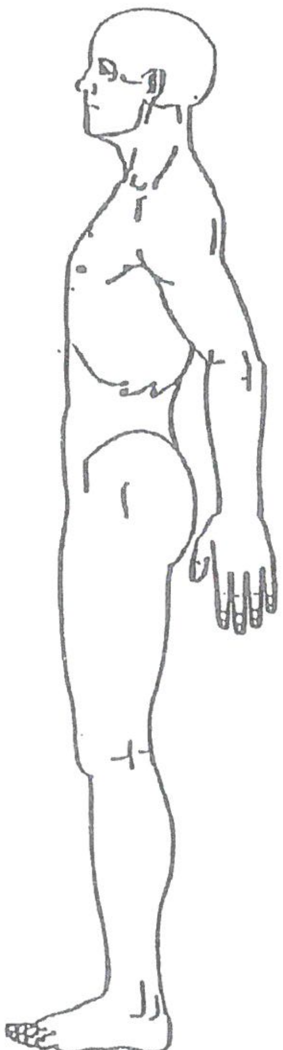
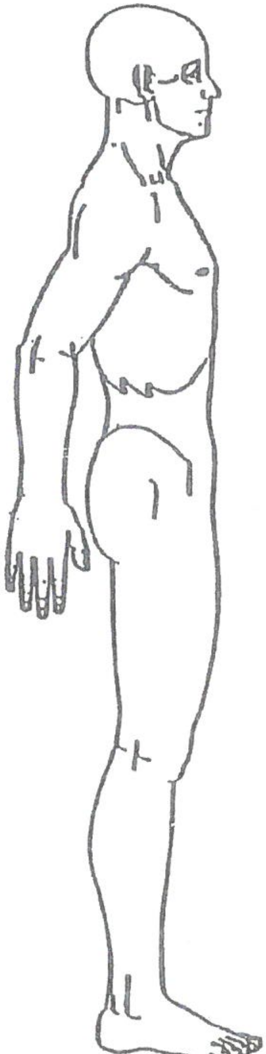
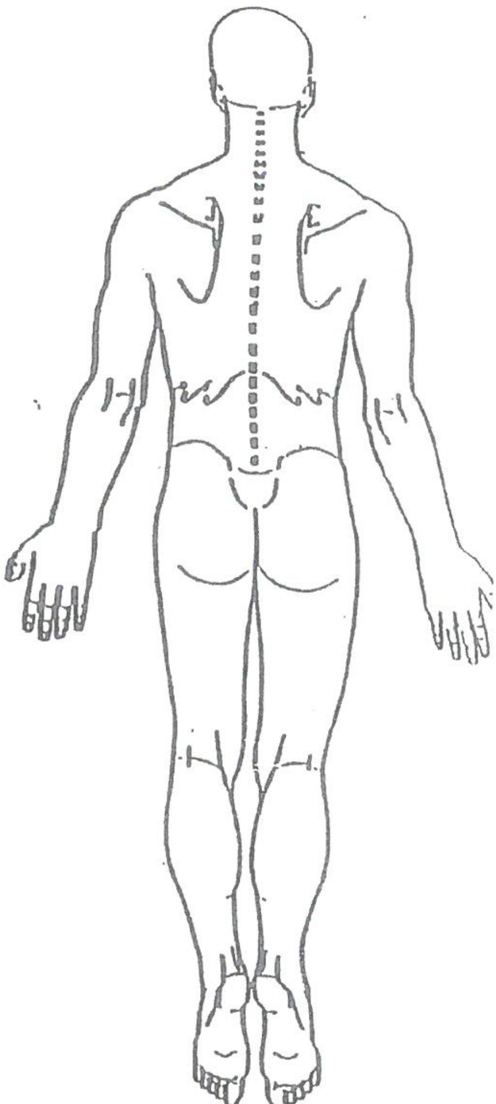
Please indicate the approximate year (or date) of your last:

Complete physical exam:	**Cardiovascular Evaluation**
Gastrointestinal evaluation:	EKG
Upper GI (endoscopy)	Echocardiogram
Lower GI (colonoscopy)	Stress test
Ultrasound	**Xrays - Imaging**
Thyroid	CT scan
Pelvis	MRI
Gall bladder	Chest Xray
Abdomen	Mammogram
Other	Other

DO YOU EXERCISE?	NONE	DAILY	2-3x/WK	DAILY
EXERCISE PROGRAM	LIGHT	MODERATE	HEAVY	COMPETITIVE
HEALTH HABITS	Smoking	Alcholol	Caffiene	Stress level

Please list all major illnesses, surgeries, emotional traumas, etc. Include issues of concern you but have been brushed aside by other healthcare practitioners.

Signature: Today's Date:

MARK AREA(S) OF PAIN ON DIAGRAM ABOVE

NOTE: Use The Following Key	Ache: /// Burning: BBB Numbness: XXX	Pins/Needles: = = = Stabbing: ZZZ Other: OOO

MEDICATION HISTORY

Please list all of the prescription medications you are CURRENTLY taking, and the dosage strength. If you are taking a generic medication, please include the common name, (ex: Fluoxitine is **Paxil**; ex: Omeprazole is **Prilosec**).

	Medication name (generic)	Medication name (common)	Dosage Strength	# times/day	OVER THE COUNTER MEDICATIONS	Dosage Strength	# times/day	MEDICATIONS YOU HAVE TAKEN IN THE PAST (NAMES ONLY)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

SUPPLEMENTS YOU ARE CURRENTLY TAKING

	Supplement		Dosage Strength	# times/day	Supplement	Dosage Strength	# times/day
14							
15							

DRUG, SUPPLEMENT, FOOD AND ENVIRONMENTAL ALLERGIES/INTOLERANCES

	MEDICATIONS ALLERGY	SUPPLEMENT ALLERGY
1		
2		
3		
4		
5		
6		
7		
8		

ENVIRONMENTAL ALLERGIES

	Dogs	Grass	Smoke	Dairy	Rabbits	Mold	Other:
	Cats	Spring pollen	Perfumes	Wheat	Guinea pigs	Sugars	Other:
	Birds	Fall pollen	Chemicals	Corn	Rag Weed	Food dyes	
	Horses	Dust		Fructose	Poison Ivy		

Signature:	Today's Date:

PHYSICAL HISTORY - SYMPTOMS

Please put an X next to all symptoms you are currently experiencing.

GENERAL COMPLAINTS		GASTROINTESTINAL		MENTAL - EMOTIONAL		MUSCULOSKELETAL	
Alcohol problems		Abdominal pain		ADD		Ankle pain	
Drug addiction		Alt diarrhea/constipation (IBS)		ADHD		Foot pain	
Cancer - current. Type?		Always hungry		Anorexia		Headaches - cluster	
		Bloating		Bulimia		Headaches - migraine	
Cancer - past. Type?		Blood/black stools		Chronic anxiety		Headaches - tension	
		Burping to excess		Compulsive behavior		Hip pain	
THYROID		Constipation		Depression		Knee pain	
Constipation		Daily diarrhea		Excessive fatigue		Low back pain	
Dry hair		Excessive gas		Excessive irritability		Neck pain	
Dry skin		GERD or reflux		Insomnia		Shoulder pain	
Feel cold		Hemorrhoids		Nervousness		Osteoarthritis	
Goiter		Jaundice		Poor memory		Osteopenia	
Hair loss		Pain after eating		Sleep difficulties		Osteoporosis	
High cholesterol		Stomach pain after eating				Rheumatoid arthritis	
Hyperthyroid diagnosis							
Hypothyroid diagnosis		**RESPIRATORY - LUNGS**		**NEUROLOGICAL**		**URINARY - REPRODUCTIVE**	
Unexplained wt gain		Asthma		History of Concussions		**MEN**	
		Recurent sinus infections		History of stroke		Difficulty urinating	
CARDIOVASCULAR		Hay fever/seasonal allergies		Lightheaded - continual		Elevated PSA level: ______	
Ankle swelling		Frequent colds		Lightheaded - periodical		Enlarged prostate	
Cannot sleep lying flat		Emphysema		Neuropathy - feet		Erectile dysfunction	
Chest pain with activity		COPD		Neuropathy - other		Incontinence	
Heart murmur		Chronic bronchitis		Vertigo - room spins		Kidney stones	
High blood pressure						Testicular pain	
High cholesterol		**DENTAL HISTORY**		**SKIN PROBLEMS**		**WOMEN**	
High triglycerides		Braces		Dermagraphia		Bleeding after intercourse	
Leg cramps with walking		Jaw locking/popping		Eczema		Irregular menses cycle	
Palpitations		TMJ pain		Hives - chronic		Painful intercourse	
		Extractions		Hives - occasional		PMS symptoms	
		Dentures		Psoriasis		Urinary incontinence	
		Wear day time mouth guard		Rashes		Vaginal dryness	
		Wear night time mouth guard		Sun sensitivity		Number of pregnancies: _____	
						Age first menses: __________	
						Date last pap: __________	
						Date last mammogram: ______	
						Date last thermogram: _____	

Past medical history - more than 6 months ago

Blood clots		Other:					
Blood transfusion		Other:					
Cancer		Other:					
Diverticulitis		Other:					
Heart attack							

Past surgical history

What type of surgery?		DATES					

ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

Signature:

Today's Date: