

## Welcome to The Center of Integrative Medicine LLC!

Congratulations on taking this important step toward improving your health through our integrative health service all-in-one healing solution. Our integrative wellness clinic is dedicated to providing you personalized holistic healing solutions and functional nutrition. If this is your first visit with an integrative clinic, it is important that you understand that we provide individualized healing solution by **analyzing and supporting body physiology, functioning of the organs, microbiome profile, hormonal & emotional balances, metabolism, nutritional status, genetic history, etc.**

If you would like to know how we differ from conventional medical practices, please review the contents of our website, [www.integmeds.com](http://www.integmeds.com), as it discusses in detail everything you need to know about our center and what to expect during your consultation. Our doctors prescribe as needed conventional medicines along with lifestyle guidelines, and non-invasive regenerative IV nutrition drip therapies for regaining your perfect health. In this document you will find our comprehensive 'New Patient Intake Form' with Health Questionnaire and Diet Assessment, which we ask that you complete in its entirety within **48 hours after scheduling your appointment** with us to confirm your appointment. Completing this form in a timely manner will ensure that we have all the information necessary to provide you with the best care possible. Also included in this document is our Informed Consent and Financial Policy.

It is important that you read and understand these policies thoroughly prior to your appointment. If you have any questions or concerns in regards to these forms please contact us. We also recommend submitting **all medical records or recent lab reports (if any) to our office prior to your appointment as one PDF** file to our email, [info@integmeds.com](mailto:info@integmeds.com), with the patient's full name and date of birth included in the email. This will allow our medical doctors to review your medical history before your consultation.

On the date of your appointment we ask that you arrive **15 minutes before** your in-person or virtual appointment to ensure that your consultation starts on time or as soon as your selected doctor becomes available. We also ask that you **avoid consuming any coffee, tea, turmeric, fruit and smoothies** on the day of appointment for better assessment. Lastly, please **bring any medications and supplements** in every visit that you are currently taking to your consultation. However, if you are currently taking any medication, do not change or stop any medicine unless you consult with your PCP or specialized doctor as our wellness clinic do not treat or diagnose your diseases.

Once again we appreciate you having entrusted us with your wellness care needs and are very excited that you are taking this very important step toward achieving your health goals.

We look forward to seeing you!

With Best Regards,

Dr. Rajesh Vindhya, MD  
Dr. M. Mojibul Haque, ND, PhD  
Dr. Sara Florida, L.Ac., PhD  
Dr. Demian Merian, DC  
And, The Center of Integrative Medicine Team

## Patient Intake and Health History Questionnaire

**Integrative health and wellness requires our doctors to have a complete picture of the patient's physical, mental, and emotional health.** In order for us to analyze and support body physiology, inflammation & functioning of the body organs, bacterial/microbiome profile, hormonal & emotional balances, metabolism, nutrition, genetic history, etc. Please fill out this intake form and health questionnaire to the best of your ability. The more information you can provide, the better we can serve your health needs. All information provided on this intake form and during your office visit is confidential. Your time, thoroughness, and honesty will greatly aid us in assessing and restoring your health. Please consider copying and saving this form for your records.

### Personal Profile

First Name: \_\_\_\_\_ M.I: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.      Weight: \_\_\_\_\_ lbs

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Partnership

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about The Center of Integrative Medicine? \_\_\_\_\_

### Medical Information:

List of Current Major Health Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medical Records and Lab Reports:

Please send over copies of current (within the past 2 years) medical reports and lab reports to us via email at [info@integmeds.com](mailto:info@integmeds.com). All medical records and lab results MUST be condensed into one PDF. file.

Date of last physical exam: \_\_\_\_\_ Date of last lab test: \_\_\_\_\_ Blood Type (if known): \_\_\_\_\_

### For Males Only:

Are you sexually active? \_\_\_\_\_ Yes \_\_\_\_\_ No Current form of contraception: \_\_\_\_\_

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss:

\_\_\_\_\_

### For Females Only:

Date of last OB/GYN exam: \_\_\_\_\_ Date of last Pap smear test: \_\_\_\_\_

Results of last Pap smear test: \_\_\_\_\_

### Childhood/Adolescence:

How was your health as a child? \_\_\_\_\_ Excellent \_\_\_\_\_ Good (typical illnesses) \_\_\_\_\_ Chronically ill \_\_\_\_\_

Were you troubled by any of the following?:

- Acne
- Allergies
- Asthma
- Eczema
- Fatigue
- Chronic Bronchitis
- Chronic Ear Infections
- Stomach Problems
- Depression
- Learning/Behavioral Problems
- Other Chronic Infections: \_\_\_\_\_
- Other: \_\_\_\_\_

**Current Medications and Nutritional Supplement List:**

Please list all current medications and nutritional supplements below.

Medication/Supplement Name:	Reason for taking:	Dosage (mg/day):	Date Started:	Side Effects:

**Diet Assessment:**

Please list all foods and beverages consumed within the last 2 days.

	Day 1	Day 2
<b>Breakfast</b>		
<b>Morning Snack</b>		
<b>Lunch</b>		
<b>Afternoon Snack</b>		
<b>Dinner</b>		
<b>Dessert</b>		
<b>Evening Snack</b>		

## The Center of Integrative Medicine Financial Policy and Fees:

We understand that your time is valuable and therefore our responsibility is to ensure that we are running on time for your appointment. However, in order to do so we ask that every patient **arrives 15 minutes prior to their in-person or virtual appointment**. This ensures that your appointment begins and ends accordingly and that you get the full-allotted time for your visit. However, if you are more than 5 minutes late to your appointment, you will be required to reschedule. A new office visit or initial virtual consultation is 20-minutes long. If you do not visit our office within 6 months, you will be required to have another new patient visit/virtual consultation for a complete re-evaluation.

New Patient Visit Fee: 20-minute office visit or virtual consultation: \$250.00

*(A comprehensive examination during the initial consultation allows for uncovering underlying health issues and exploring possible solutions)*

\*Nutritional supplements and laboratory work are NOT included in the price of this consultation fee. This amount will vary based on your evaluation. (Note: All supplements purchased through The Center of Integrative Medicine are already marked down 15-30% off as a courtesy of being a patron of our office. Please note that *supplements are not returnable in any situation as per company policy.*)

I have read the above information and I accept the policies of The Center of Integrative Medicine

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Credit Card Authorization Form:

In order to confirm your booking we must collect a cashless payment method to hold your appointment date and time. Please note that your debit/credit card will NOT be charged to hold this appointment. However, if you DO NOT show up for your appointment or cancel less than 48 hours before your appointment, your account will be charged for the full amount of the consultation cost. Your appointment is very important to us and the staff at The Center of Integrative Medicine, we ask that if you need to make any revisions to your booking, please let us know at your earliest convenience via phone, text, or email. Thank you for your compliance.

\*Type of Debit/Credit Card (*please circle any*) Visa or Mastercard or AmEx or Discover or Other \_\_\_\_\_

\*Card Number: \_\_\_\_\_ Expiration date: \_\_\_\_\_ CVC: \_\_\_\_\_

\*By signing this form you authorize The Center of Integrative Medicine LLC to charge your card for your consultation 48 hours before your appointment and for any missed appointment fees.

Print: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_