

Transformational Healthcare

Transformational Healthcare is committed to helping you achieve the health and well-being you wish to experience.

Attached are new patient forms for your appointment with Dr. Denice Hilty. Please fill out the forms completely and bring them with you to your appointment. Please bring any additional information you feel would be useful during your visit. Should you need to reschedule, please notify us two (2) full business days prior to your appointment.

The first visit with the doctor is 90 minutes long and includes a comprehensive consultation, examination, report of findings and initial treatment. The fee is \$325.00 (pediatric - 60 minutes, \$275.00) paid by cash, check, or credit card (Visa, Mastercard, American Express). If you would like to submit an insurance form for reimbursement to your insurance company an appropriate form will be provided by our office.

We are located just north of Madison Square Park at:

60 Madison Avenue, Suite 1012
Between 26th & 27th Streets

Please contact our office if you have further questions or need driving or subway directions at **212-620-4114** or **www.transformationalhealthcare.net**.

We look forward to helping you!

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*Note: This is a confidential record of your medical history. Information contained here will not be released to any person without your authorization.

IDENTIFICATION DATA: Please fill in completely. **Please Print.**

Name: _____ Date : _____

Address: _____ Apt _____

City _____ State _____ Zip Code _____

Date of Birth: _____ Age : _____ Occupation : _____

Home / Mobile Phone () _____ Business Phone () _____

Email Address: _____ Referred by: _____

*Would you like our monthly informational newsletter on advancing your health?: yes no, thank you

• Status: Single Married Other • Vocation: Employed Full-Time Student Part-Time Student

Emergency Contact: Name _____ Phone # _____

Reason for your visit today: _____

Date of Last Physical: _____ Reason(s) For Visit: _____

MAJOR HOSPITALIZATIONS : For **serious** medical illnesses/operations. Do not include normal pregnancies.

YEAR REASON FOR OPERATION/ ILLNESS

FRACTURES/TRAUMAS : Please include the year/description of the incident. Traumas may be **physical** or **emotional**.

MEDICATIONS : Please list the names and duration of any **medications, vitamins, or herbs** that you are currently taking.

ALLERGIES: Please list any allergies or sensitivities you have to medications, foods, chemicals, grass, trees and others.

FAMILY HISTORY : Please list any pertinent information regarding your family's health history.

Grandparents: _____

Parents: _____

Siblings: _____

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HABITS:

Alcohol. # of Drinks per week _____ Age Began _____ Stopped _____

Caffeine. # of Coffees per day _____ # of Teas per Day _____ # of sodas per day _____

Tobacco _____cigarettes / packs a day Age Began _____ Stopped _____

Marijuana. Use Per Day _____ Age Began _____ Stopped _____

Other Street Drugs. Please specify Drug (s) _____ Frequency _____ Stopped _____

PERSONAL HEALTH HISTORY . Please place a “ C ” next to any conditions that you are currently experiencing, and a “ P ” next to any pertinent conditions that you may have experienced in the past.

GENERAL

___ Aversion To Cold / Heat / Damp
___ Chills
___ Fever
___ Sweat easily ___ only with exertion
___ Low Energy ___ Uneven Energy
___ High ___ Low Blood Pressure
___ Hyper ___ Hypo Thyroid Disorder
___ Diabetes ___ Low Blood Sugar
___ Cancer
___ Chemical Dependency
___ Sleep Difficulties
___ History Emotional Difficulties
___ HIV
___ TB
___ Hepatitis A, B, C, D, E
___ Herpes
___ Frequent Exposure To Blood
___ Transfusion before 1985
Other _____

CARDIOVASCULAR

___ Palpitations
___ Chest Pain ___ Tightness
___ Rapid Heart Beat
___ Irregular Heart Beat
___ Pacemaker
___ Poor Circulation
___ Cold Hands ___ Feet
___ Swelling of Ankles
___ Phlebitis
Other _____

GASTROINTESTINAL

___ Poor Appetite
___ Excessive Hunger
___ Anorexia ___ Bulimia
___ Tastes In The Mouth
___ Chronic Bad Breath
___ Never Thirsty ___ Always Thirsty
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Indigestion
___ Gas
___ Bloating

___ Belching
___ Heartburn
___ Ulcers
___ Stomach Cramps ___ Pain
___ Bowel Changes
___ Constipation ___ Diarrhea
___ Rectal Bleeding ___ Bloody Stools
___ Hemorrhoids
___ Mucus / Phlegm in stool
___ Recent Changes in Weight
___ Gallbladder Disorder
Other _____

Food Cravings. If Yes For What:

RESPIRATORY

___ Chronic Cough
___ Coughing up Blood
___ Coughing up Phlegm
___ Difficulty Breathing
___ Shortness of Breath
___ Wheezing ___ Asthma
___ Bronchitis
___ Excess Sputum
___ Frequent Colds
___ Sinus Bleeding
___ Sinus Infection
___ Hay Fever / Allergies
___ Changes in Smell
___ Sore Throat
___ Hoarseness. Difficulty Swallowing
Other _____

SKIN

___ Itching
___ Hives
___ Rashes
___ Acne
___ Eczema
___ Boils
___ Nonhealing sores
___ Scars
___ Changes in Moles ___ Lumps
___ Dryness
___ Bruise Easily
___ Scar Tissue, location _____
Other _____

HEAD & NECK

___ Dizziness
___ Fainting
___ Headaches
___ Neck Stiffness
___ Enlarged Lymph Glands
___ Hairloss / Thinning

___ Visual Changes
___ Double Vision
___ Dry Eyes
___ Blurred Vision
___ Poor Night Vision
___ Spots / Floaters
___ Eye inflammation

___ Oral Ulcers
___ Jaw Problems/ TMJD

___ Discharge from Ear
___ Ear Infection
___ Ringing in the Ears
___ Decreased Hearing

Other _____

NEUROLOGICAL

___ Poor Coordination
___ Difficulty Walking
___ Seizures
___ Tremors
___ Numbness / Tingling Of Limbs
___ Nerve Pain
___ Paralysis
Other _____

STRUCTURAL HEALTH

___ Pain ___ Radiation
___ Arthritis / Joint Disorder
___ Weak / Sore Muscles
___ Spinal Curvature
Other _____

What do you do for exercise?

How many times per week? _____

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GYNECOLOGICAL

- Frequent UTI
- Frequent Vaginal Infections
- Pain Itching Of Genitalia
- Genital Lesions
- Discharge
- Pelvic Inflammatory Dis
- Abnormal Pap Smear
- Abnormal Bleeding
- Breast Lumps
- Fibroids
- Painful Intercourse
- Low Sex Drive
- Nipple Discharge
- Water Retention
- Hot Flashes
- Irregular Menstruation
- Painful Menstruation
- PMS. What are your symptoms?

MALE REPRODUCTIVE

- Weak/ Frequent/ Dripping Urinary Stream
- Painful Urination
- Burning Urination
- Blood In The Urine
- Cloudy Urination
- Pain in the Genitalia
- Itching Of The Genitalia
- Genital Lesions
- Discharge
- Impotence
- Low Sex Drive / Difficult Erection
- Premature Ejaculation
- Painful Intercourse
- Prostate Disorder
- Lumps In The Testicle
- Other _____

Date Of Last Pap Smear _____ Date Of Last Mammogram _____ Date of Last Breast Thermography _____

Age Of First Menstruation _____ End Of Last Menstrual Period (Date) _____ Intervals (Days) _____

Duration Of Flow (Days) _____ Amount _____ Color _____ Clots _____ Consistency _____

Age Of Menopause _____ Any Bleeding Since _____ Menopausal / Perimenopausal Symptoms _____

Current Method Of Contraception _____

History and details of the birth control pill use _____ How Long? _____

Currently Pregnant. Yes _____ No _____ Unsure _____

Previous Pregnancies. Please Fill In

<i>Year</i>	<i>Length Of Pregnancy</i>	<i>Labor Hours</i>	<i>Sex</i>	<i>Weight</i>	<i>Name</i>	<i>Complications</i>
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____

Total Pregnancies _____ # Living _____ # Ectopic _____ # Of Miscarriages _____ # Of Induced Abortions _____

Is there anything that you feel is important that has not been covered? _____

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Meals- please give a description of your daily food intake and include the **time of day**.

	Day 1	Day 2	Day 3
Breakfast	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Lunch	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Dinner	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
Snacks	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
•Comments:	_____		

Please answer the following questions:

(If needed use the back page or additional paper to express your answers)

1. If you could experience optimal health and well-being how would it feel and look? What would you like to change about your current symptoms (ex. fatigue → robust energy)?
2. Rate from 1-10 how much you view your health and well-being, as a struggle and expand? ____
3. What are 3 experiences or circumstances would you like to be different in your life?
4. Name 3 or more experiences or circumstances of what you would create in your life?
5. What makes you feel good and/or what are your sources of pleasure?

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Office Policy

We value our patient's time as much as we do our own and pride ourselves on keeping your wait to a minimum. We understand travel in Manhattan can be challenging and will accommodate a late arrival for a scheduled appointment the best we can.

You are responsible for payment of missed appointments or appointments rescheduled with less than 24 hours notice; however we will make every effort to fill that time for you.

Payment is expected at the time service is rendered. We accept credit cards (Visa, Master Card, American Express) cash or personal checks.

If you have health insurance, we will provide you with a detailed receipt for your paid visit which you may use for submission to you insurance carrier. If you need care following a personal, work or car accident injury, we do not accept direct assignment from health insurance companies, Worker's Compensation, No Fault or Medicare. If you need a healthcare provider who does accept direct assignment, we will do our best to help you find one. We will be glad to and are required to file Medicare forms on your behalf.

Signature

Date