Health History Intake & Face Sheet

Vibrant Health Imaging & Integrative Care

Name: _____ Date of birth: _____ Age: _____
Address: _____ Date of service: _____
_____ Type of imaging/ROI: _____
Cell Phone: _____ Home Phone: _____
Email: _____ Occupation: _____

Please answer the following questions as thoroughly as possible.

Why are you here? _____

Current issues/active surveillance? _____

General health assessment? _____

Any current symptoms/concerns? (if so, please note date of symptom onset.) _____

What do YOU think is going on? _____

General Health Diagnoses (please include year of diagnoses): _____

Current treatment: _____

Current healing team: (check all that apply)
☐ MD ☐ DO ☐ NP ☐ PA
☐ chiropractic ☐ massage ☐ therapist ☐ colon hydrotherapy
☐ ND ☐ personal coach ☐ nutritionist ☐ personal trainer
☐ energy work ☐ other: _____

Current meds/supplements: _____

Dental History (please indicate if you have any of the following and note locations if possible):
metal fillings _____ crown _____
bridge _____ root canal _____
caps _____

Please describe in detail any past or current issues in the following areas, well as any illnesses, injuries or surgical interventions with dates and outcomes:

Ear Nose Throat/allergy: _____

Skin/Lymphatic health: _____

Joint & Muscle health: _____

Cardiovascular/Circulatory health: _____

Endocrine/Hormonal health: _____

Digestive health: _____

Psychiatric health: _____

Respiratory health:_____

Reproductive/Urinary health: _____

Inflammatory issues: _____

Cancer diagnoses: _____

Breast issues or surgeries: (including any previous findings on clinical breast exam, thermal imaging, ultrasound, or mammogram) _____

Locations of surgical scars/skin lesions: _____

Family history: _____

Current Dietary Choices: _____

Current Lifestyle habits:

Exercise regime? _____
Alcohol use? _____
Sleep habits? _____
Elimination issues? _____
Life stress _____

Family constellation/support team? _____

What brings you the most joy? _____

Anything you feel in need of right now? _____

What do you hope to gain as the result of this appointment? _____

Are there any other areas that you are seeking assistance in with regards to your mental/physical/emotional/spiritual health/wellbeing?_____

***Form of report: Your DITI report will arrive by secure EMAIL as a digital file unless otherwise noted.**
***Check here ☐ if you do not wish to have your report shared with a healthcare provider. OR see below.**

The information contained on this document is as accurate and complete as possible. I authorize *Vibrant Health Imaging, LLC* to send copies of my DITI reports to the following healthcare providers. This authorization shall expire only upon my written request. (For each name listed, please note provider's full name, credential, contact information, and specialty/relation to you. EG: primary care provider, massage therapist; breast surgeon.)

1. _____

2. _____

3. _____

_____ _____

Signature *Date of service*