Chart # __ __ - __ __ __ __

Holistic and Integrative Healing LLC
Dr. Nancy Iankowitz DNP, RN, APRN, FNP-BC
ANCC Board Certified Family Nurse Practitioner
Doctor of Nursing Practice
(917) 716-6802

By Appointment Only

CONFIDENTIAL PERSONAL INFORMATION

Date: _____

Full Legal Name: _____ / _____ / _____
(Last Name) (First Name) (Middle Name)

Age: ____ Date of Birth: _____ SS# (last 4 digits only): __ __ __ __

Address: _____ / _____ / _____ / _____
(Street# / PO Box) (City) (State) (Zip Code)

Telephone # (_____) _____ / _____ / _____
Home Work Cell/ other

E-mail address: _____ Gender ***(I consider myself)***: M __ F __

Occupation: _____ Full time/ Part time/ Student/ Retired/ Unemployed

Employer and/or School: _____ Date of Graduation: _____

Emergency Contact: _____ / _____
(Name) (Relationship)

( ) _____ ( ) _____
(Daytime Phone) (Evening Phone)

Between office visits, please communicate with me via: E-mail: __ (below) Phone ___ (below)

This is where **a full detailed health-related/appointment confirmation message may be left**:

E-mail _____ Phone ( ) _____ and/or ( ) _____

My healthcare may be discussed freely with _____

Do not discuss my healthcare with _____

I would like Dr. Iankowitz to send me educational materials via e-mail Yes ____ No____

I would like Dr. Iankowitz to e-mail me links/recommended articles and/or health information specifically related to my personal medical condition(s). Yes ___ No___

Please note: E-mail is NOT a secure communication. All e-mail correspondence will become part of your medical record.

In order to take responsibility for my own health and wellness, I am fully aware that I am partnering with Dr. Iankowitz along my personal healing journey; thus, before changing my current health practices, I agree to use my own discretion by looking-up, consulting with other trusted professionals and thoroughly investigating all recommendations.

Patient's Signature: _____ Date: _____

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Personal Medical History *(please circle and/or check all that apply)*

I have a primary healthcare provider (MD, DO, ND, NP, PA, other) ☐ YES ☐ NO
I am being treated by and/or have a medical specialist on my health care team ☐ YES ☐ NO

I give permission to Dr. Iankowitz to reach out, on my behalf and in my best interest, to discuss my medical status with members of my health care team ☐ YES ☐ NO ☐ N/A

Contact information for my other healthcare provider(s):

Name	Address	Phone #

I would like to be referred to a specialist and/or primary healthcare provider ☐ YES ☐ NO

***I have a personal medical history of/ diagnosis, and/or had surgery involving*:**

Diagnosis	Yes	No	Not Sure	For which I take this medication	Year (if surgery and/or hospital stay)
Diabetes					
Hypertension					
Asthma					
High Cholesterol					
Anxiety					
Depression					
Glaucoma					
Lyme					
Multiple Sclerosis					
GERD					
Crohn's					
An Autoimmune condition *Specify*				*Specific details of diagnosis and treatment:*	
Hepatitis (A, B or C) *Circle what applies*					
Heart murmur					
Heart (other)					

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Diagnosis	**Yes**	**No**	**Not Sure**	**For which I take this medication**	**Year** *(if surgery and/or hospital stay)*
Liver					
Kidney					
Headaches					
Muscles					
Spine / posture					
Stomach/ GI					
Other					
Not sure. Check with my provider		Name _____ Phone _____ I give permission to Dr. Iankowitz to reach out on my behalf ☐ YES ☐ NO			

I have been examined/treated by a chiropractor within the past five (5) years ☐ YES ☐ NO

I have been treated by an acupuncturist within the past five (5) years ☐ YES ☐ NO

I have been treated by a massage therapist within the past five (5) years ☐ YES ☐ NO

I have been examined/treated by an energy healer within the past five (5) years ☐ YES ☐ NO

I have been examined/treated by a licensed, medical specialist within the past five years ☐ YES ☐ NO

I have taken and/or currently take supplements (vitamins, herbs, minerals etc.), over-the-counter treatments, ***under the care of*** a medical, nursing or mental health professional ☐ YES ☐ NO

I have taken and/or currently take at least one supplement (vitamin, herb, mineral etc.), over-the-counter treatment on my own, ***without*** consulting a licensed healthcare provider ☐ YES ☐ NO

I have the following concerns about my current or past health: _____
_____
_____
_____

Today, I am seeking examination and treatment for: _____
_____
_____
_____

I would like to know more about *(list any treatments, medication, conditions, information you heard from friends/ radio/ television*): _____
_____
_____
_____

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	I have participated in classes			I'm interested in learning more about			I currently teach*	
	YES	**NO**	**MAY HAVE**	**YES**	**NO**	**MAYBE**	**YES**	**NO**
Yoga								
Tai Chi								
Qi Gong								
Meditation								
Karate								

**If you have taught any of these, write "taught" in the space under "YES"*

To assess risk for intestinal parasites, sexually transmitted &/or blood borne infections:

I have a cat or dog ☐ YES ☐ NO Veterinary care is up-to-date ☐ YES ☐ NO ☐ N/A

I had / have contact with farm animals ☐ YES *(circle one)* Recent / Frequent / On a trip ☐ NO

I have been to a foreign country within the past two years ☐ YES ☐ NO

I often have gas, belching and/or bloating after or when I eat ☐ YES ☐ NO

My stool is often: *(circle all that apply)*

Hard little rocks Ribbons Mushy Long brown banana Medium yam shape Black/bloody

I have been diagnosed with sexually transmitted infections ☐ Once ☐ ≥ Twice ☐ Never

I'm sexually active ☐ YES ☐ NO ☐ Not sure

I follow "safe sexual practices" ☐ YES ☐ NO ☐ Not sure ☐ N/A

I am interested in learning more about "safe sexual practices" ☐ YES ☐ NO ☐ Maybe

I would like to learn about how to avoid infections associated with sharing toothbrushes, hairbrushes, needles, razors and/or other things ☐ YES ☐ NO ☐ Maybe

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PHYSICAL EXAMINATION

Subjective: (chief complaint): _____
_____
_____

Objective: B/P ___/___ Ht. ___Wt. ____ BMI ___ Temp ____° F Pulse ___ Respir.___ Pulse Ox _____%

HEENT

Sinuses: Tenderness on palpation/ percussion Y N Details/Other _____

TMs: Pearly Grey Bilaterally; other _____

Throat: Uvula rises evenly; No PND; Tonsils <+1; other _____

Weber/Rinne: AC > BC bilaterally; other _____

Eyes: *OD* _____ *OS* _____ *OU* _____ *Color Perception (red/green)* Intact/other*

Visual Fields: Intact/other* *EOMs*: Light falls evenly on pupil/other*

Notes: _____

_____

Heart: *Murmurs:* None/other _____

Lungs: Clear to A & P/ other _____ Peak flo: _____ N/A

Skin: Rashes (None/other) _____

Nails: Capillary refill _____ Angle (165°)/other _____

Teeth: Missing _____ Hygiene Good/other*_____Ref. to dentist Yes__ No___ Refused by pt.___

Neuro: *Reflexes* (knee) _____ *Gait* Steady/other _____ *Orientation/Mental status*: A & O x 3/other*

GI: *Abdomen*: Deferred/other _____

Assessment:

Plan: Patient education offered: (Circle) Diet Exercise Self-Care (*B/P*; *glucose; hygiene; coping) Other* _____*

*Details: _____
_____
_____

Referrals/Follow-up: Specialist _____; Dentist_____; other _____

_____

Date of next appointment with Dr. Iankowitz: _____ PRN _____