



| PATIENT INFORMATION   | CONTACT INFORMATION  |
|---|--|
| <p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birthdate _____</p> <p>Occupation _____</p> <p>Company name _____</p> <p>Primary physician _____</p> <p>Physician phone number _____</p> <p>How did you hear about us? _____</p> <p>_____</p>   | <p>Home phone _____</p> <p>Work phone _____</p> <p>Other/cell phone _____</p> <p>Email _____</p> <p>Another person we may contact if needed:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p>   |
| HEALTH HISTORY  |  |
| <p>What are your primary concerns for coming in for treatment?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking:</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries:</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives:</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease</p> | <p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Depression</li><li><input type="checkbox"/> Difficulty in focusing</li><li><input type="checkbox"/> Dizziness</li><li><input type="checkbox"/> Easily startled</li><li><input type="checkbox"/> Excessive worry</li><li><input type="checkbox"/> Excessive anger</li><li><input type="checkbox"/> Excessive fear</li><li><input type="checkbox"/> Fatigue/tiredness</li><li><input type="checkbox"/> Headaches</li><li><input type="checkbox"/> Loss of sleep/poor sleep</li><li><input type="checkbox"/> Loss or gain of weight</li><li><input type="checkbox"/> Nervousness/irritability</li><li><input type="checkbox"/> Overwhelmed by life</li></ul> <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> AIDS</li><li><input type="checkbox"/> Allergies</li><li><input type="checkbox"/> Anemia</li><li><input type="checkbox"/> Arthritis</li><li><input type="checkbox"/> Bleeding disorders</li><li><input type="checkbox"/> Breast lump</li><li><input type="checkbox"/> Cancer</li><li><input type="checkbox"/> Diabetes</li></ul> <p>How long has it been since you have had a complete medical exam? _____</p> |

| <b>HEALTH HISTORY...CONTINUED</b>   |   |
|---|---|
| <p>Check symptoms you have or have had in the last year:</p> <p><b>MUSCLE/JOINT/BONES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tremors c Cramps</li> <li><input type="checkbox"/> Swollen joints</li> </ul> <p>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arms or Hips</li> <li><input type="checkbox"/> Back Legs</li> <li><input type="checkbox"/> Feet</li> <li><input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Hands</li> <li><input type="checkbox"/> Shoulders</li> <li><input type="checkbox"/> Other _____</li> </ul> <p><b>EYES/EAR/NOSE/THROAT/RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma/wheezing</li> <li><input type="checkbox"/> Blurred or failing vision</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Enlarged glands</li> <li><input type="checkbox"/> Eye pain</li> <li><input type="checkbox"/> Frequent colds</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Gum trouble</li> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> </ul> <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Boils</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Dry skin</li> <li><input type="checkbox"/> Itching/rash</li> <li><input type="checkbox"/> Sensitive skin</li> <li><input type="checkbox"/> Sore won't heal</li> <li><input type="checkbox"/> Sweats</li> </ul> <p><b>GENTO/URINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood/pus in urine</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Inability to control urine</li> <li><input type="checkbox"/> Kidney infection/stones</li> <li><input type="checkbox"/> Lowered libido</li> </ul> | <p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Hardening of arteries</li> <li><input type="checkbox"/> High or low blood pressure</li> <li><input type="checkbox"/> Pain over heart</li> <li><input type="checkbox"/> Poor circulation</li> <li><input type="checkbox"/> Previous heart attack</li> <li><input type="checkbox"/> Rapid/irregular heart beat</li> <li><input type="checkbox"/> Swelling of ankles</li> </ul> <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Belching, gas or bloating</li> <li><input type="checkbox"/> Colon trouble</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Distention of abdomen</li> <li><input type="checkbox"/> Excessive hunger</li> <li><input type="checkbox"/> Gall bladder trouble</li> <li><input type="checkbox"/> Hemorrhoids (piles)</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Pain over stomach</li> <li><input type="checkbox"/> Poor appetite</li> <li><input type="checkbox"/> Vomiting</li> </ul> <p><b>FOR MEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Erection difficulties</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Prostate trouble</li> </ul> <p><b>FOR WOMEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding between periods</li> <li><input type="checkbox"/> Clots in menses</li> <li><input type="checkbox"/> Excessive menstrual flow</li> <li><input type="checkbox"/> Extreme menstrual pain</li> <li><input type="checkbox"/> Irregular cycle</li> <li><input type="checkbox"/> Menopausal symptoms</li> <li><input type="checkbox"/> PMS</li> <li><input type="checkbox"/> Previous miscarriage</li> <li><input type="checkbox"/> Scanty menstrual flow</li> </ul> <p>Could you be pregnant? _____</p> |
| <b>SIGNATURE</b>  |   |
| <p>The information on this form is correct to the best of my knowledge.</p> <p>Signature _____ Date _____</p>   |   |