



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"><input type="checkbox"/> Depression<input type="checkbox"/> Difficulty in focusing<input type="checkbox"/> Dizziness<input type="checkbox"/> Easily startled<input type="checkbox"/> Excessive worry<input type="checkbox"/> Excessive anger<input type="checkbox"/> Excessive fear<input type="checkbox"/> Fatigue/tiredness<input type="checkbox"/> Headaches<input type="checkbox"/> Loss of sleep/poor sleep<input type="checkbox"/> Loss or gain of weight<input type="checkbox"/> Nervousness/irritability<input type="checkbox"/> Overwhelmed by life <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"><input type="checkbox"/> AIDS<input type="checkbox"/> Allergies<input type="checkbox"/> Anemia<input type="checkbox"/> Arthritis<input type="checkbox"/> Bleeding disorders<input type="checkbox"/> Breast lump<input type="checkbox"/> Cancer<input type="checkbox"/> Diabetes <p>How long has it been since you have had a complete medical exam? _____</p>

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