Name:________________ DOB/Age:________________ Date:____________

Address: ____

Home Phone: _____________ Work: _______________ Cell: _______________

Email: ____

Work Address: ____

Work Phone: _____________ Work Schedule: _______________

Can I Call You at Work?: Y / N

Emergency Contact: ___________________ Relationship: ____________________

Home Phone: _____________ Work: _______________ Cell: _______________

Health Proxy? Y / N

If 'YES', Proxy Name: ________________

Home Phone: __________ Work: ____________ Cell: ____________

Power of Attorney? Y / N

If 'YES', Power of Attorney Name: _________________

Home Phone: __________ Work: ____________ Cell: ____________

Insurance Information:

Company: _____________________ Phone:________________________

Group/Policy ID: _______________ Website: ______________________

For Office Use Only

HIPAA form signed? Y / N Health Proxy Provided? Y / N POA Provided? Y / N
Client Contract signed? Y / N Original w/ Advocate? Y / N Copy to Client? Y / N
Deposit collected? Y / N Amount: $____________

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Name:_______________ DOB/Age:_______________ Date:___________

Chief Complaint: ____

____

____

Treatments Tried (Indicate Treatments Currently in Place): ___________________

____

____

____

History of health condition(s): _______________________________________

____

____

____

Allergies (medications/food/environmental): ______________________________

____

____

Surgeries (Type/Date/Place): ____

____

____

Pertinent Diagnostic Testing (MRI, PET, X-Ray, etc.): _______________________

____

____

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Name:________________ DOB/Age:________________ Date:____________

Current Blood Pressure & Pulse (if known): ____________________

Current Weight: ________ Height: _______ BMI:_______

Has Your Weight Been Stable? If 'No', Why? _____________________________

____

What is your diet like? Are you on a special diet? __________________________

____

Are you on an exercise regimen? Y / N

Do you have limitations re: exercise? ___________________________________

Do you use alcohol? How much/how often? ________________________________

Have you used tobacco in the past? Are you using it now/how much? ____________

____

Do you live alone? Y / N

If "NO", Specify Members of the Household: ______________________________

____

Do you have a Support System (family, friends, etc.)? Y / N

If "YES", Specify: ____

Would you like Family and/or Support System Members to Be Involved in Discussions related to your care? Y / N

If "YES", Specify: ____

Do you have a Support System (family, friends, etc.)? Y / N

Do you have a regular hobby? ____

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Name:________________ DOB/Age:________________ Date:____________

Dental Work? Fillings? Root canals? How many amalgams do you have in your mouth?

____

____

Have you lived in other locations for an extended period of time (provide dates)? ___

____

____

What job positions have you held for an extended period of time (provide dates)? ___

____

____

Religious and Social Affiliations? ___________________________________

Have you over used Alternative Medicine (acupuncture, Reiki, Yoga, etc.)? Y / N

If "YES", Specify: ____

How do you learn best (auditory, visual, etc.)? ___________________________

Any impediments to learning? ______________________________________

Are you comfortable using computers (email, etc.)? _______________________

Preferred form of communications (phone, email, face-to-face, etc.)? ____________

Financial Concerns? ____

What are your goals for your current medical concerns? ____________________

____

____

____

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Name:________________ DOB/Age:________________ Date:____________

Systems Review (List Any Other Current or Past Issues in These Areas):

Cardiovascular: ____

Central Nervous System: ____

Peripheral Nervous System: _______________________________________

Urinary: ____

Reproductive: ____

Digestive: ____

Musculoskeletal: ____

Dermatological: ____

Immunological/Lymphatic System: _________________________________

Dental: ____

Endocrine: ____

Respiratory: ____

Senses (Eye/Ear/Nose/Tactile): ____________________________________

Other:____

What concerns you most about your medical future? _________________________

____

What medical needs do you have that are currently not being met? ____________

____

Are you using any community resources to aid with this condition? (List) _________

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Name:____________________ DOB/Age:_________________ Date:_______________

Physicians involved in patient care:

Name: _________________________ Specialties: ______________________________

Address: ____

Phone: __________________ Fax: ________________ Cell: ____________________

Website: ____

Name: _________________________ Specialties: ______________________________

Address: ____

Phone: __________________ Fax: ________________ Cell: ____________________

Website: ____

Name: _________________________ Specialties: ______________________________

Address: ____

Phone: __________________ Fax: ________________ Cell: ____________________

Website: ____

Name: _________________________ Specialties: ______________________________

Address: ____

Phone: __________________ Fax: ________________ Cell: ____________________

Website: ____

Name: _________________________ Specialties: ______________________________

Address: ____

Phone: __________________ Fax: ________________ Cell: ____________________

Website: ____

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Name:________________ DOB/Age:________________ Date:____________

Medications, Vitamins, and Supplements:

________________________________ ______________________________

________________________________ ______________________________

________________________________ ______________________________

________________________________ ______________________________

________________________________ ______________________________

________________________________ ______________________________

________________________________ ______________________________

Do you have your medical records? Y / N

Instructions for Obtaining Your Medical Records are Provided Below

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Name:________________ DOB/Age:________________ Date:____________

Additional Notes:

____

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