PATIENT INFORMATION & CONTACT INFO:

Name:_____

Date: _____

Address:_____

City, State & Zip:

_____

Home phone:_____

Work phone:_____

Other/cell phone:_____

Is it okay for me to reach you at any of these numbers? □ Yes □ No

Email:_____

Check here to opt out of email updates: ___

Age:_____ Birthdate:_____

Gender: _____ Pronoun: _____

Height:_____ Weight:_____

Filing status: Married or Single:_____

Yearly Household Income:_____

Occupation:_____

Company name: _____

Primary physician & phone number :

_____

Another person we may contact if needed:

Name:_____

Relationship:_____

Phone:_____

How did you hear about us? _____

HEALTH HISTORY:

What are your primary concerns for coming in for treatment?

1:_____

2:_____

How many hours do you average a night of sleep? ____ Any sleep complaints (wake often, hard to fall a sleep, etc.)?_____

How many meals do you average a day?_____

How many snacks do you average a day?_____

Are you hungry for them?_____

Give a rough estimate of how much of your diet is *processed foods* (Added preservatives, additives, chemicals & fast food)? _____%

How much is *whole foods*? (One ingredient food items: Meats, Plant Staches, Grains, Good fats, Fruits & Veggies)? _____%

How much water do you average a day?_____

Do you have an excercise regimen, if so explain:

_____

_____

Circle your stress level: mild, moderate or severe. Please list the top 3 stressors in your life:

_____

_____

Do you practice any type of relaxation practices, if so explain?_____

_____

On average how many bowel movements do you have a day?_____

Do you drink caffeine, alcohol, use tobacco or any recreational drugs? If so, how much and often for each:_____

_____

Are you currently taking any pain medication or blood thinners? (including aspirin) Yes No

List all medications or food supplements you are taking: _____

_____

_____

List serious illnesses, diagnoses, accidents, or surgeries _____

_____

_____

List any known allergies: _____

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How long since your last complete medical exam?_____

Check symptoms YOU have had in the past &

Circle symptoms YOU currently have :

□ Anxiety □ Addiction

□ Depression □ Difficulty in focusing

□ Dizziness □ Easily startled

□ Excessive worry or fear

□ Excessive anger or irritability

□ Overwhelmed by life □ Fatigue/tiredness

□ Headaches □ Migraines

□ Loss or gain of weight

□ Allergies □ Anemia

□ Arthritis □ Bleeding disorder

□ Cancer: type_____

□ Diabetes □ Head Trauma

□ Hepatitis (type_____) □ HIV/AIDS

□ Hypo/hyper thyroid □ Pacemaker

□ Seizure □ Stroke

MUSCULOSKELETAL

□ Tremors □Muscle cramps

□ Swollen joints: where? _____

Any Discomfort? Indicate what area of the body and describe the discomfort (pain, numbness, etc.)

□ Hand □ Back

□ Wrist □ Hips

□ Arm □ Buttocks

□ Elbow □ Leg

□ Shoulder □ Knee

□ Neck □ Ankle

□ Head □ Foot

EYES/EAR/NOSE/THROAT/RESPIRATORY

□ Asthma/wheezing □ Blurred or failing vision

□ Difficulty breathing □ Earache

□ Enlarged glands □ Eye pain

□ Frequent colds/flus □ Hay fever

□ Hoarseness □ Gum pain or bleeding

□ Nose bleeds □ Loss of hearing

□ Persistent cough □ Ringing in ears

□ Sinus problems

GASTROINTESTINAL

□ Belching □ Bloating

□ Gas □ Colon issues

□ Constipation □ Diarrhea

□ Difficulty swallowing □ Excessive hunger

□ Gall bladder trouble □ Hemorrhoids

□ Indigestion or pain □ Nausea

□ Poor appetite □ Vomiting

CARDIOVASCULAR

□ Chest pain □ Hardening of arteries

□ High blood pressure □Low blood pressure

□ Pain over heart □ Poor circulation

□ Previous heart attack

□ Rapid/irregular heart beat

□ Swelling of ankles

SKIN

□ Acne □ Boils

□ Bruise easily □ Dry skin

□ Itching/rash □ Sensitive skin

□ Sore won't heal □ Sweats

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URINARY

□ Bladder or urinary tract infection

□ Blood/pus in urine □ Bed Wetting

□ Frequent urination □ Inability to control urine

□ Kidney infection/stones

REPRODUCTIVE

MALE:

□ Lowered libido □ Increased libido

□ Erection difficulties □ Penis discharge

□ Prostate issues □ Infertility

FEMALE:

□ Lowered libido □ Increased libido

□ Abnormal vaginal discharge

□Infertility

□ Breast tenderness □ Breast lump

□ Bleeding in between periods

□ PMS symptoms, explain: _____

□ Menstrual pain

□ Clots in menses

□ Excessive menstrual flow

□ Scanty menstrual flow

□ Irregular menstrual cycle

□ Menopausal symptoms

□ Previous miscarriage (# ____)

□ Pregnancies to term (# ____)

Could you be pregnant?_____

Please add any other symptoms or concerns that you have:

Circle all illnesses that have occurred to *blood relatives:*

Diabetes, High blood pressure, Stroke, Cancer, Heart disease, Kidney disease & other serious diagnosises?

The information on this form is correct to the best of my knowledge.

PRINTED NAME:

_____

Date_____

PATIENT SIGNATURE:

_____

(Or Patient Representative)