

PATIENT INFORMATION	CONTACT INFORMATION																						
<p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birth date _____</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 vitamin 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> <table border="0"><tr><td><input type="checkbox"/> Depression</td><td><input type="checkbox"/> Difficulty in focusing</td></tr><tr><td><input type="checkbox"/> Dizziness</td><td><input type="checkbox"/> Easily startled</td></tr><tr><td><input type="checkbox"/> Excessive worry</td><td><input type="checkbox"/> Excessive anger</td></tr><tr><td><input type="checkbox"/> Excessive fear</td><td><input type="checkbox"/> Fatigue/tiredness</td></tr><tr><td><input type="checkbox"/> Headaches</td><td><input type="checkbox"/> Loss of sleep/poor sleep</td></tr><tr><td><input type="checkbox"/> Loss or gain of weight</td><td><input type="checkbox"/> Nervousness/irritability</td></tr><tr><td><input type="checkbox"/> Overwhelmed by life</td><td></td></tr></table> <p>Check conditions you have or have had in the past:</p> <table border="0"><tr><td><input type="checkbox"/> AIDS</td><td><input type="checkbox"/> Allergies</td></tr><tr><td><input type="checkbox"/> Anemia</td><td><input type="checkbox"/> Arthritis</td></tr><tr><td><input type="checkbox"/> Bleeding disorders</td><td><input type="checkbox"/> Breast lump</td></tr><tr><td><input type="checkbox"/> Cancer</td><td><input type="checkbox"/> Diabetes</td></tr></table> <p>How long has it been since you have had a complete medical exam? _____</p>	<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		<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
<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																							
<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																						
HEALTH HISTORY...CONTINUED																							

Check symptoms you have or have had in the last year:

**MUSCLE/JOINT/BONES**

- Tremors c Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms
- Back or Hips
- Legs
- Feet
- Neck
- Hands
- Shoulders
- Other \_\_\_\_\_

**EYES/EAR/NOSE/THROAT/RESPIRATORY**

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

**SKIN**

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

**GENITO/URINARY**

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

**CARDIOVASCULAR**

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

**GASTROINTESTINAL**

- Belching, gas or bloating
- Colon trouble
- Distention of abdomen
- Constipation
- Diarrhea
- Excessive hunger
- Difficulty swallowing
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

**FOR MEN ONLY**

- Erection difficulties
- Penis discharge
- Male infertility
- Prostate trouble

**FOR WOMEN ONLY**

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Irregular cycle
- Extreme menstrual pain
- PMS
- Menopausal symptoms
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? \_\_\_\_\_

**SIGNATURE**

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

Signature \_\_\_\_\_ Date \_\_\_\_\_