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Patient Information

Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Name _____
Last Name First Name

Today's date ____/____/____ Male Female

Date of Birth ____/____/____ Age ____ SS# _____

Marital Status Single Married Separated Divorced Widower Other

Home Address _____ City _____ State ____ Zip _____

Home phone () _____ work () _____ cell () _____

email address _____

Occupation _____ Employer _____

Employer Address _____

Primary Care Doctor _____

Are you currently under the care of a doctor or specialist? If yes, please explain. _____

Insurance Information

Company Name _____ Policyholder Name _____

Policy Number _____ Group Number _____

Emergency Contact

Name _____ Relationship to you _____

Address _____ City _____ State _____ Zip _____

Daytime phone () _____ evening () _____ cell () _____

Referred by

Name _____ Internet (search engine: google, yahoo, etc)
 Brochure: Please specify _____
 Workshop (date) _____
 Other _____

Cancellation Policy

Please understand that your appointment time is reserved for you. I understand that there may be occasions when you need to cancel or reschedule an appointment. If you need to cancel or reschedule your appointment for any reason, I require a minimum of 24 hour advanced noticed to avoid cancellation/ rescheduling fees in the amount of your scheduled time. Thank you kindly for respecting this policy.

Major Complaints

Please list in order of importance what complaints are of concern to you , along with the duration of complaint.

- 1. _____ mild / moderate / severe
- 2. _____ mild / moderate / severe
- 3. _____ mild / moderate / severe

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

- AIDS/HIV
- Tuberculosis
- Measles
- Allergies
- Seizures
- Goiter
- Diabetes
- Alcoholism
- Mumps
- Epilepsy
- Ulcers
- Pleurisy
- Multiple Sclerosis
- Emphysema
- Typhoid Fever
- Pacemaker
- Appendicitis
- Stroke

- Arteriosclerosis
- High blood pressure
- Chicken Pox
- Scarlet Fever
- Cancer
- Herpes
- Other (please specify)
- Heart disease
- Thyroid disorder
- Whooping cough
- Pneumonia
- Rheumatic fever
- STD
- Surgery
- Gout
- Polio
- Asthma
- Hepatitis
- Major Trauma

Your Lifestyle

- Alcohol
 - Marijuana
 - Tobacco
 - Drugs
 - Stress
 - Occupational Hazards
 - Regular exercise
- Type _____
- Frequency _____

General Symptoms

- Poor appetite
- Heavy appetite
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Bleed or bruise easily
- Poor sleep
- Heavy sleep
- Dream disturbed sleep
- Fatigue
- Lack of strength
- Vertigo or dizziness
- Bodily heaviness
- Cold hands & feet
- Poor circulation
- Shortness of breath
- Fever
- Chills
- Night Sweats
- Sweat Easily
- Muscle cramps

Head, Eyes, Ears, Nose, Throat

- Glasses
- Headaches
- Swollen glands
- Excessive saliva
- Teeth Problems
- Other head or neck problems
- Excessive phlegm
- Ringing in ears
- Blurred vision
- Night blindness
- Eye strain
- Migraines
- Lumps in throat
- Sinus problems
- Poor vision
- Gum Problems
- Sores on lips or tongue
- Glaucoma
- Eye Pain
- Concussions
- Enlarged thyroid
- Itchy Eyes
- Spots in eyes
- Facial Pain
- Earaches
- Recurrent sore throat
- Dry Mouth
- Cataracts
- Red Eyes
- Grinding teeth
- TMJ Color of phlegm
- Poor hearing

Respiratory

- Difficulty breathing when lying down
- Pneumonia Thick or thin?
- Tight chest
- Shortness of breath
- Cough
- Coughing blood
- Asthma/wheezing

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain
- Tachycardia
- Blood clots
- Fainting
- Difficulty breathing
- Heart palpitations
- Irregular heartbeat

Gastrointestinal

- Nausea
- Vomiting
- Acid regurgitation
- Gas
- Hiccup
- Bloating
- Diarrhea
- Constipation
- Laxative use
- Black stools
- Bloody stools
- Mucous in Stool
- Intestinal pain or cramping
- Itchy anus
- Burning anus
- Rectal pain
- Hemorrhoid
- Anal Fissures
- Bad Breath

Musculoskeletal

- Neck/shoulder pain
- Muscle pain
- Other (describe) _____
- Upper back pain
- Low back pain
- Joint pain
- Rib pain
- Limited range of motion
- Limited use

Skin and Hair

- Rashes
- Psoriasis
- Ulcerations
- Other hair/skin problems _____
- Eczema
- Itching
- Acne
- Dandruff
- Fungal infections
- Hair loss
- Change in hair/skin texture
- Hives

Neuropsychological

- Seizures
- Numbness
- Tics
- Other (specify) _____
- Poor memory
- Depression
- Anxiety
- Irritability
- Easily Stressed
- Considered/attempted suicide
- Seeing a therapist

Genito-Urinary

- Pain on urination
- Impotence
- Decreased Libido
- Wake to urinate
- Blood in Urine
- Frequent urination
- Premature ejaculation
- Kidney stone
- Venereal disease
- Unable to hold urine
- Urgent urination
- Nocturnal emission
- Increased Libido
- Bedwetting
- Incomplete urination

Gynecology

Age Menses began _____ Duration of flow _____

Date of last menstrual cycle _____ Length of cycle _____

Age at menopause _____

- Irregular Periods
- Painful Periods
- PMS
- Vaginal Discharge
- Other _____

Are you currently pregnant? _____

of pregnancies _____

of miscarriages _____

Breast lumps

Medical Conditions

Please list any surgeries you have had, allergies or occupational concerns

Type and year of surgery _____

Allergies _____

Occupational Concerns:

- Stress
- Heavy Typing/Computer
- Hazardous Substances
- Heavy Lifting
- Other

Medications

Please list all prescription medication you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.

Prescription Name	Purpose & For How Long	Dose & How Often	Last Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature _____ date _____

