

PATIENT INFORMATION	CONTACT INFORMATION
Date _____ Name _____ Address _____ City State Zip _____ Age _____ Birthdate _____ Occupation _____ Company name _____ Primary physician _____ Physician phone number _____ How did you hear about us? _____ _____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____ Another person we may contact if needed: Name _____ Relationship _____ Home phone _____ Work phone _____

HEALTH HISTORY	
What are your primary concerns for coming in for treatment? 1- _____ 2 - _____ 3 - _____ How is your sleep? _____ _____ How is your digestion? _____ _____ List medications or food supplements you are taking. _____ _____ List serious illnesses, accidents or surgeries. _____ _____ Check illnesses that have occurred in blood relatives. Diabetes High blood pressure Stroke Cancer Heart disease Kidney disease	Check symptoms you have or have had in the last year: <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 Check conditions you have or have had in the past: <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 How long has it been since you have had a complete medical exam? _____