



Patient Information

Contact Information

Date _____
 Name _____
 Address _____
 City, State, Zip _____
 Age _____ Birthdate _____
 Occupation _____
 Primary Physician _____
 How did you hear about us? _____

Home Phone _____
 Work Phone _____
 Cell _____
 Email _____
(we will never share your info)
 > another person we may contact if needed:
 Name _____
 Relationship _____
 Home Phone _____
 Work Phone _____

Health History

What are your primary reasons for treatment?

How is your Sleep? _____

How is your Digestion? _____

What medications / supplements do you take?

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 had in the last year:

- Depression
- Difficulty with mental focusing
- Dizziness/
- Easily Startled
- Excessive Worry
- Excessive Anger
- Excessive Fear
- Fatigue / Tiredness/
- Headaches/
- Loss of Sleep / Poor Sleep
- Loss or Gain of Weight
- Nervousness / Irritability
- Overwhelmed by Life
- Environmental Sensitivities

Check conditions you have had in the past:

- AIDS Bleeding Disorders
- Allergies Breast Lump
- Anemia Cancer
- Arthritis Diabetes

How long has it been since your last medical exam?

Health History, continued

Check any symptoms you have had in the last year:

Muscle / Joint / Bones

- Tremors / Cramps
- Swollen Joints

Pain, Weakness, Numbness in:

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

Eyes, Ear, Nose, Throat, Respiratory

- Asthma / Wheezing
- Blurred or Failed 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 that 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 the 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
- Constipation
- Diarrhea
- Heartburn
- Difficulty Swallowing
- Distention of Abdomen
- Excessive Hunger
- Gall Bladder Trouble
- Hemorrhoids
- Indigestion
- Nausea
- Pain Over Stomach
- Poor Appetite
- Vomiting

Please Check If Applicable

- Erection Difficulty
- Penis Discharge
- Prostate Trouble
- Bleeding Between Periods
- Clots in Menses
- Excessive Menstrual Flow
- Extreme Menstrual Pain
- Irregular Cycle
- Menopausal Symptoms
- PMS
- Previous Miscarriage
- Scanty Menstrual Flow

Could You Be Pregnant? _____

Do You Have Children? _____

Their Ages _____

Please Sign Below, Thank You.

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

Signature: _____

Date: _____ / _____ / _____