PATIENT INFORMATION

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION REQUESTED

PATIENT NAME_____DATE _____

HOME ADDRESS_____CITY_____

STATE _____ZIP_____DRIVER'S LICENSE_____

CELL PHONE_____ HOME PHONE_____

EMAIL_____

EMPLOYER_____OCCUPATION_____

DATE OF BIRTH _____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?_____

ADDRESS_____CITY_____

STATE_____ZIP_____Relationship _____

HOME PHONE_____ WORK PHONE_____

PERSON RESPONSIBLE FOR PAYMENT_____

IS PATIENT A MINOR?_____ GUARDIAN_____

PERMISSION IS GRANTED TO RENDER TREATMENT, SIGNATURE PARENT OR GUARDIAN:

_____ DATE_____

WHO REFERRED YOU TO US _____

CAN WE TEXT YOU FOR APPOINTMENT REMINDERS? _____YES _____NO

MEDICAL HISTORY

What are your health concerns at this time, both medical and psychological?

_____

_____

Indicate the accidents, injuries and hospitalizations you have had:

1. _____Date or Age_____
2. _____Date or Age_____
3. _____Date or Age_____

Have you had the: Measles_____ Mumps_____Chickenpox_____

List any unusual childhood illnesses you may have had. (i.e., rheumatic fever,

pneumonia, etc ..) _____

FAMILY HISTORY

In your family is there any history of:

	No	Yes	Family Member
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Hepatitis/Infectious Mono	☐	☐	_____
HIV	☐	☐	_____
Hypertension	☐	☐	_____
Kidney Disease	☐	☐	_____
Mental Illness	☐	☐	_____
Stroke	☐	☐	_____
T.B.	☐	☐	_____

Other _____

Medications

List any prescribed medication(s) that you are presently taking:

MEDICATION	DOSAGE	REASON
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

What vitamins and/or supplements do you regularly take?

_____

_____

Are you allergic to the following substances?

If yes, please list.

1.Medication / drugs_____
2.Food / supplements_____
3.Other_____
4.Seasonal Allergies_____ Asthma_____ Eczema_____
5.Do you drink coffee or black tea_____if so, how much per day?_____

Do you smoke cigarettes?_____ if so, how many a day?_____

Do you drink alcohol?_____if so, how often?_____

Do you use marijuana or cocaine?_____ if so, which & how much & how often?

_____

Do you eat sugar?_____ if so, how often, what kind? _____

Do you exercise?_____ if so, how often? _____

FEMALES ONLY

Are you or might you be pregnant? Yes_____ No_____ Maybe_____

If yes, what month? _____

What method of birth control do you use? _____

Are you experiencing reduced sexual energies? _____ Other difficulties? _____

Do you have regular PAP tests? _____ Was any PAP test abnormal? _____

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Menstrual Cycle:

____Irregular

____Painful

____Excess of blood

____Lack of blood

____Dark

____Light

____Heavy clotting

____Water retention

____Painful breast

Gynecological History or operations:

___Ovaries _____
____Uterus _____
____Tubes _____
____Vagina _____
____Breast _____
____Other _____

Pregnancy:

___Total number: _____ ___Number of abortions: _____

___Number of children: _____ ___Number of miscarriages: _____

___Complications: _____

Vaginal Discharge:

____Yellow ____White ____Thick ____Odor ____Other

MALES ONLY:

Please check or explain where necessary

____Dribbling/weak stream of urination_____ ____Pain in genitals_____

____Reduced sexual energies_____ ____Discharges_____

———Premature ejaculation_____ ____Other_____

____Uncontrolled seminal emission_____ ____Difficulty with erection_____

IN THE LAST SIX MONTHS WHICH OF THE FOLLOWING SYMPTOMS HAVE YOU EXPERIENCED?

	NEVER	SOMETIMES	OFTEN
Belching or Burping	_____	_____	_____
Clammy Hands	_____	_____	_____
Digestion Problems	_____	_____	_____
Excessive Appetite	_____	_____	_____
Feeling of Retention of Food in Stomach	_____	_____	_____
Heartburn	_____	_____	_____
Indigestion	_____	_____	_____
Lack of Appetite	_____	_____	_____
Nausea	_____	_____	_____
Tendency to be "Obsessive" in Work Relationships	_____	_____	_____
Thirsty	_____	_____	_____
Vomiting	_____	_____	_____
Blood in Stool	_____	_____	_____
Blood-tinged Septum	_____	_____	_____
Bronchitis	_____	_____	_____
Chills	_____	_____	_____
Colitis or Diverticulitis	_____	_____	_____
Constipation	_____	_____	_____
Cough	_____	_____	_____
Dry Cough	_____	_____	_____
Cough with Thick Mucus	_____	_____	_____
Cough with Thin Mucus	_____	_____	_____
Decreased Sense of Smell	_____	_____	_____
Feeling of "Claustrophobia"	_____	_____	_____
Fever	_____	_____	_____

	NEVER	SOMETIMES	OFTEN
Frequent Sore Throats	_____	_____	_____
Hemorrhoids	_____	_____	_____
Nasal Problems	_____	_____	_____
Night Sweats	_____	_____	_____
Recent use of Antibiotics	_____	_____	_____
Shortness of Breath	_____	_____	_____
Skin Problems	_____	_____	_____
Sweating without Exercise	_____	_____	_____
Varicose Veins	_____	_____	_____
Blood in Urine	_____	_____	_____
Burning upon Urination	_____	_____	_____
Decreased Sex Drive	_____	_____	_____
Frequent Urination at Night	_____	_____	_____
Frequent Urination	_____	_____	_____
Hair Loss	_____	_____	_____
Hearing Impairment	_____	_____	_____
Kidney Stones	_____	_____	_____
Knee problems	_____	_____	_____
Low Back Pain	_____	_____	_____
Painful Urination	_____	_____	_____
Ringing in Ears	_____	_____	_____
Urine Retention	_____	_____	_____
Anger	_____	_____	_____
Angina Pains	_____	_____	_____
Anxiety	_____	_____	_____
Cries a Lot	_____	_____	_____
Depression	_____	_____	_____

	NEVER	SOMETIMES	OFTEN
Dizziness	_____	_____	_____
Fear	_____	_____	_____
Heart Palpitations	_____	_____	_____
Insomnia	_____	_____	_____
Laughing for no Apparent Reason	_____	_____	_____
Nightmares	_____	_____	_____
Poor Memory	_____	_____	_____
Difficulty Digesting Oily Foods	_____	_____	_____
Difficulty Making Plans/Decisions	_____	_____	_____
Easily Angered or Agitated	_____	_____	_____
Eye Problems	_____	_____	_____
Gall Stones	_____	_____	_____
Hepatitis	_____	_____	_____
Jaundice (Yellow Eyes or Skin)	_____	_____	_____
Light Colored Stools	_____	_____	_____
Pain Under Ribs	_____	_____	_____
Soft or Brittle Nails	_____	_____	_____
Spasm or Twitching of Muscles	_____	_____	_____
Burning Feet or Hands at Night	_____	_____	_____
Difficulty to Stop Bleeding	_____	_____	_____
Dry Skin	_____	_____	_____
Easily Bruised	_____	_____	_____
Edema	_____	_____	_____
Fatigue	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol Levels	_____	_____	_____
Hot Flashes	_____	_____	_____

	NEVER	SOMETIMES	OFTEN
Intolerant to Weather Changes	_____	_____	_____
Joint Swelling	_____	_____	_____
Muscle Weakness	_____	_____	_____
Numbness, Tingling	_____	_____	_____
Oily Skin	_____	_____	_____
Paralysis	_____	_____	_____
Sudden Weight Loss	_____	_____	_____
Tendency to Catch Colds Easily	_____	_____	_____
Tendency to Faint Easily	_____	_____	_____
Tendency to be Cold	_____	_____	_____
Abdominal Pain	_____	_____	_____
Chest Pain	_____	_____	_____
Headaches	_____	_____	_____
Sciatic Pain	_____	_____	_____
Other	_____	_____	_____