

We value your time and your knowledge of your condition. We also recognize that one part of the body can affect function in another part. So, this important information will help the doctor help you most quickly and completely.

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: Male/Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status:  Single  Partner  Married  Separated  Divorced  Widow(er)

Describe your **MAJOR PROBLEM(s)** or **Reason for office visit** and **WHEN Did It BEGIN?**  
\_\_\_\_\_  
Started: \_\_\_\_\_  
\_\_\_\_\_  
Started: \_\_\_\_\_

**Is this?** Work Related Auto Related Neither  
Time of the day do you feel **most energy or least symptoms** Time of the day do you feel **least energy or most symptoms**  
 Morning  Afternoon  Evening  Night  Morning  Afternoon  Evening  Night

**Other conditions or symptoms** you have for which you desire to be examined/treated **Now OR Eventually**:  
\_\_\_\_\_  
Started: \_\_\_\_\_  
\_\_\_\_\_  
Started: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name \_\_\_\_\_ MD / DC / DO Location \_\_\_\_\_

**Laboratory procedures** performed (e.g., stool analysis, blood and urine chemistries, hair analysis):  
\_\_\_\_\_

Results \_\_\_\_\_

**Imaging procedures** performed (e.g. x-ray, MRI, CT): \_\_\_\_\_

Results \_\_\_\_\_

What **types of therapy** have you tried for this problem(s)?  diet modification  fasting  vitamins/minerals  herbs  
 homeopathy  chiropractic  acupuncture  Physical Therapy  Counseling  conventional drugs  
 other \_\_\_\_\_

List other current health problems for which you are being treated: \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? YES / NO

**Recent changes** in your ability to:  see  hear  taste  smell  feel hot/cold sensations  
 move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Are you recovering from a **cold or flu**? YES / NO Are you **pregnant**? YES / NO  
Circle the level of **stress** you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major **causes of stress** (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you wear?  Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right **Height** \_\_\_\_\_ Your **weight today** is \_\_\_\_\_ lbs

Is your sleep disturbed at the same time each night? YES / NO If yes, what time? \_\_\_\_\_ am/pm Reason? \_\_\_\_\_

- Stroke Risk:** **1)** Do you bruise Easily? YES / NO; **2)** Do you have a History of Migraine headaches YES / NO;  
**3)** Are you feeling a RECENT, Sudden(over 1- 30 minutes), UNCOMMON (to you) neck or head pain? YES / NO;  
**4)** Are you noticing MORE difficulty, Walking, Feeling, Seeing, Swallowing or have new Dizziness or Vertigo  
that IS NOT directly related to the **Discomfort**? YES / NO  
-- Answering Yes to question 3 plus any other is reason to seriously consider emergency room care.

Do you experience any of these general symptoms **MOST DAYS**?

<input type="checkbox"/> Constipation	<input type="checkbox"/> fecal incontinence	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Low grade fever
<input type="checkbox"/> Debilitating fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Disinterest in sex	<input type="checkbox"/> Headaches	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Discharge
<input type="checkbox"/> Disinterest in eating	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Itching/rash	<input type="checkbox"/> Chronic pain/inflammation

**Medical History (of yourself)**

- Carpal tunnel syndrome
- Dental problems
- Depression
- Diabetes
- Drug addiction
- Alcoholism
- Eating disorder
- Learning disabilities
- Mental illness
- Mental retardation
- Epilepsy
- Alzheimer's disease
- Migraine headaches
- Neurological problems
- Ex. (Parkinson's, paralysis)
- Eyes, ears, nose, throat problems
- Glaucoma
- Environmental sensitivities
- Chronic fatigue syndrome
- Fibromyalgia
- Autoimmune disease
- Arthritis
- Osteoporosis
- Gout
- Cancer
- Infection, chronic
- Food intolerance
- Gastroesophageal reflux (GERD)
- Inflammatory bowel disease
- Irritable bowel syndrome
- Ulcer
- Diverticular disease
- Colitis
- Kidney or bladder disease
- Liver disease
- Gallbladder disease (stones)
- Sinus problems
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Asthma
- Allergies/hay fever
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Urinary tract infection
- Cholesterol, elevated
- Heart disease
- Stroke
- Blood pressure problems
- Thyroid trouble
- Obesity
- Circulatory problems
- Varicose veins
- Genetic disorder \_\_\_\_\_
- Other \_\_\_\_\_
- None of the above

**Medical (Men)**

- Benign prostatic hyperplasia (BPH)
- Prostate cancer
- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Erectile Dysfunction (<50yo=50%+1HtA)
- Other \_\_\_\_\_
- None of the above

**Medical (Women)**

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- 
- None of the above

**Menstrual cycle Not Started yet**

- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control  N/A \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Surgical menopause
- Natural Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Days between cycles: \_\_\_\_\_ days

**Family Health History (Parents, Sibling, relatives)**

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis, etc.)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_
- 
- None of the above

**Health Habits**

- Water: \_\_\_\_\_ #glasses / day / wk
- Juices: \_\_\_\_\_ #glasses / day / wk
- Other Drink : \_\_\_\_\_ #glasses / day / wk \_\_\_\_\_
- Alcohol: \_\_\_\_\_
- Wine: \_\_\_\_\_ #glasses / day / wk
- Liquor: \_\_\_\_\_ #glasses / day / wk
- Beer: \_\_\_\_\_ #glasses / day / wk
- Caffeine: \_\_\_\_\_
- Coffee: \_\_\_\_\_ #6 oz cups/d
- Tea: \_\_\_\_\_ #6 oz cups/d
- Soda w/caffeine: \_\_\_\_\_ #cans/day
- Other sources \_\_\_\_\_
- Tobacco: \_\_\_\_\_
- Cigarettes: #/day \_\_\_\_\_
- Cigars: #/day \_\_\_\_\_

**Exercise**

- I do not work out
- I attend a gym
- I have home exer equipment / stab ball
- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Cycle
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Yoga
- Other \_\_\_\_\_

**Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:**
- dairy  wheat  eggs
- soy  corn  all gluten
- Other \_\_\_\_\_

**Food Frequency(average) (Servings(=palm-full size) per day:)**

- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Processed grains(bread, cereal, etc.) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy \_\_\_\_\_
- Eggs(how many) \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

**Eating Habits (you may mark several)**

- Skip breakfast
- 1 meal per day
- 2 meals per day
- 3 Meals per day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

**Current Supplements**

- I do not take supplements
- Multivitamin/mineral
- If yes, brand \_\_\_\_\_
- Vitamin C / E / A
- CoQ10
- Antioxidants (e.g., lutein, etc.)
- Omega fatty acids (EPA/DHA, etc.)
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium, Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- Herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Herbs - teas
- Other \_\_\_\_\_

**Sleeping Habits**

\_\_\_\_\_ hours per night, usually

**I would like ASSISTANCE to:**

- Be free of pain
- Be free of numbness
- Have more energy
- Be thinner / lower body fat
- Have healthier nails / hair
- Think more clearly / focused
- Not be dependent on medications, incl. aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives / stool softener
- Reduce Digestive Problems
- Sleep better
- Get less colds and flus
- Get rid of allergies
- Have agreeable body odor
- Detoxification / Cleansing
- ADHD / Autism / Dyslexia
- Improve Sports Performance
- Reduce Fatigue
- Slow Arthritis Degeneration
- Have Pregnancy / Delivery comfort
- Reduce risk of inherited disease (e.g., cancer, heart disease, etc.)
- Other \_\_\_\_\_

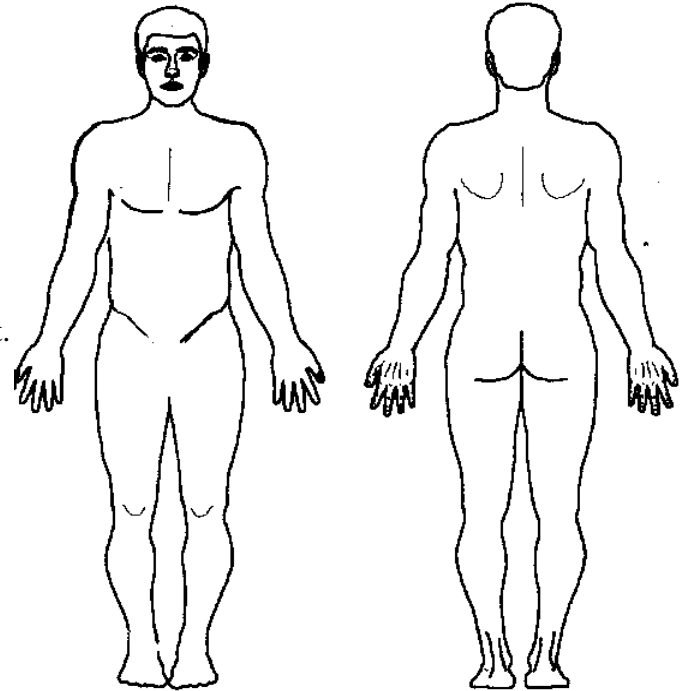
MUCH A Little

Please mark (with a number) the sites of any significant

**surgeries, accidents, or injuries – do your best.**

Then describe it in the numbered spaces below.

You may use a number in multiple sites if the single injury involved more than one location.



**When**

**What happened and/or What for?**

Example: Jan '04 left knee cartilage surgery after football injury.

I have had no surgeries, or only (circle) Tonsils, Wisdom t.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Note: If your have a list , you may leave this blank and give us the list to copy.

I am taking no medications

Medications	What for?	When Started?	Still Taking it?	How often?
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly

Family Physician name \_\_\_\_\_

(If you approve, we'll send them a summary of our findings about you.) Sign Here if you approve: \_\_\_\_\_

**How did you decide** to come to our office (mark **ALL that affected** in your decision)

- Friend or Relative \_\_\_\_\_ (If we know who, we'll send them a "Thank You.")
- Doctor or other practitioner \_\_\_\_\_
- Insurance       Our Website       Other \_\_\_\_\_

**PATIENT AGREEMENT**

**Initial** I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment.

If the health plan information is not accurately communicated by the insurance company, or if I am not eligible to receive a health care benefit through this provider, or if I need a referral from my primary physician, I understand that I am liable for all charges for services rendered. I agree to notify this doctor immediately whenever I have changes in my health plan coverage in the future.

In order to provide time for other patients to be scheduled, I will give 24-hour notice if I am not able to keep a scheduled appointment or I will be subject to a \$25.00 charge because my insurance cannot be billed for this time.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SPOUSE'S OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_