



PATIENT INFORMATION

Date: _____

Name: _____

Called Name: _____

Address: _____

Female: ___ Male: ___

Age: _____

Birthdate: _____

Single: ___ Married: ___ Divorced: ___

SSN: _____

Occupation: _____

Employer: _____

Employer's Address: _____

Spouse's Name: _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home: _____

Work: _____

Cell: _____

E-Mail Address: _____

(will not be given out)

Supplements taken regularly (and reason):

INSURANCE

Who is responsible for this account:

Relationship to Patient: _____

Cardholder's Name: _____

Birthdate: _____

SSN: _____

Assignment and Release

I understand that I am financially responsible for all charges whether paid or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of the signature on all insurance submissions.

Responsible Party Signature

Date

Surgeries: _____

Major

Injuries: _____

Medications taken regularly (and reason):

Reason for visit: _____

Please check conditions or symptoms you currently have or have had in the past:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pinched Nerve
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Jaw Pain/TMJ	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis

Routine physical exercise: Type of exercise: _____
Minutes per day? _____ Times per week? _____

Dietary preferences/restrictions: _____

TOBACCO	AMOUNT	CAFFEINE	AMOUNT	ALCOHOL	AMOUNT
<input type="checkbox"/> Current/Pks per day	_____	<input type="checkbox"/> Coffee	_____	<input type="checkbox"/> Wine	_____
<input type="checkbox"/> Previous/Pks per day	_____	<input type="checkbox"/> Tea	_____	<input type="checkbox"/> Beer	_____
How long has it been		<input type="checkbox"/> Soda	_____	<input type="checkbox"/> Hard Liquor	_____
since you quit? _____		<input type="checkbox"/> Chocolate	_____		

Are there health hazards that you are exposed to at home/work, such as toxic chemicals, dust, fumes, etc?
 Yes No If yes, describe: _____

Do you suffer from any form of arthritis? Yes No Location _____

Do you suffer from headaches? Yes No How often? _____

Do you have persistent stomach pain, indigestion, or trouble with bowel movements, such as constipation or diarrhea? Yes No If yes, describe _____

Do you suffer from specific symptoms of ill health, such as:

Irritability Yes No

Difficulty in concentrating Yes No

Mood Swings Yes No

Dizziness, trembling, palpitations Yes No

Brain fog/loss of mental acuity Yes No

Concerns about your present weight Yes No

Anxiety, sadness, and depression for which there is no situational explanation Yes No

Inexplicable drops in your strength stamina at various times throughout the day Yes No

Is your stress level Low Medium High

WOMEN ONLY

Are you pregnant? Yes No

Date of last menstrual cycle? _____

Are you experiencing any female related complaints at this time? Yes No

Explain: _____

Have you experienced any problems in the past? Yes No

Explain: _____

How many pregnancies? _____ How many births? _____

Did you have any difficulties or complications during pregnancy or delivery? _____
