WELCOME

Please Print Legibly

PATIENT INFORMATION

Name____
Last Name First Name Middle Initial

Whom may we thank for referring you to our office for care? ____________________

Address ____________________City ____________ State ________Zip________

Cell Phone____________Home Phone____________ Work Phone____________

Email Address ____________________ Sex ❑ M ❑ F Date of Birth ____________

Age ____________ ❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for______years

Employer/School ____________________

Spouse Name ____________________ Spouse Date of Birth____________

Does your spouse have any health concerns you would like to share with us? ____________________

Emergency Contact Information:

Name ____________________

Cell Phone____________Home Phone____________ Work Phone____________

Relationship ____________________

How many children do you have: ____________

Ages Health Concerns you would like to share with us

PATIENT CONDITIONS/CONCERNS

What are the primary concerns that bring you to our office

Concern	Date of onset
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

HEALTH HISTORY

Current Treatment for Condition ____________________

Prior Treatment ____________________

Are you taking any prescription drugs? ❑ Yes ❑ No

Please List ____________________

____

____

Are you taking any nutritional supplements? ❑ Yes ❑ No

Please List ____________________

____

____

Habits/Addictions ❑ tobacco - chew/smoke ❑ coffee ❑ alcohol ❑ other ____________________

Prior Surgeries ❑ Yes ❑ No

Please List ____________________

____

____

DIAGNOSTIC TESTING

	Date	Facility
❑ Bloodwork	________	________
❑ MRI	________	________
❑ X-Ray	________	________
❑ Ultrasound	________	________
❑ Cat Scan	________	________
❑ Mammogram	________	________
❑ Other	________	________
❑ Other	________	________

PAST HISTORY

AIDS/HIV ❑ Yes ❑ No
Alcoholism ❑ Yes ❑ No
Allergy Shots ❑ Yes ❑ No
Anaphylaxis ❑ Yes ❑ No
Anemia ❑ Yes ❑ No
Anorexia ❑ Yes ❑ No
Appendicitis ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Bleeding Disorders ❑ Yes ❑ No
Blood Clots ❑ Yes ❑ No
Breast Lump ❑ Yes ❑ No
Bronchitis ❑ Yes ❑ No
Bulimia ❑ Yes ❑ No
Cancer ❑ Yes ❑ No
Cataracts ❑ Yes ❑ No
Chemical Dependency ❑ Yes ❑ No
Chicken Pox ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No

Emphysema ❑ Yes ❑ No
Epilepsy ❑ Yes ❑ No
Fractures ❑ Yes ❑ No
Fungal Infections ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No
Goiter ❑ Yes ❑ No
Gonorrhea ❑ Yes ❑ No
Gout ❑ Yes ❑ No
Heart Disease ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No
Hernia ❑ Yes ❑ No
Herniated Disk ❑ Yes ❑ No
Herpes ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No-
High Cholesterol ❑ Yes ❑ No
Kidney Disease ❑ Yes ❑ No
Liver Disease ❑ Yes ❑ No
Measles ❑ Yes ❑ No
Migraine Headache ❑ Yes ❑ No

Miscarriage ❑ Yes ❑ No
Mononucleosis ❑ Yes ❑ No
Multiple Sclerosis ❑ Yes ❑ No
Mumps ❑ Yes ❑ No
Osteoporosis ❑ Yes ❑ No
Pacemaker ❑ Yes ❑ No
Parkinson's Disease ❑ Yes ❑ No
Pinched Nerve ❑ Yes ❑ No
Pneumonia ❑ Yes ❑ No
Polio ❑ Yes ❑ No
Prostate Problem ❑ Yes ❑ No
Prosthesis ❑ Yes ❑ No
Psychiatric Care ❑ Yes ❑ No
Rheumatoid Arthritis ❑ Yes ❑ No
Rheumatic Fever ❑ Yes ❑ No
Scarlet Fever ❑ Yes ❑ No
Sexually Transmitted Disease ❑ Yes ❑ No

Stroke ❑ Yes ❑ No
Suicide Attempt ❑ Yes ❑ No
Thyroid Problems ❑ Yes ❑ No
Tonsillitis ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Tumors, Growths ❑ Yes ❑ No
Ulcers ❑ Yes ❑ No
Urinary Tract Infection ❑ Yes ❑ No
Vaginal Infections ❑ Yes ❑ No
Yeast/Candida Infections ❑ Yes ❑ No
Whopping Cough ❑ Yes ❑ No
Other ____________________

____

____

____

FAMILY HISTORY

Please List Relationship

❑ Cancer ____________________

❑ High Blood Pressure ____________________

❑ Diabetes ____________________

❑ Heart Disease ____________________

❑ Stroke ____________________

❑ Dementia ____________________

❑ Alzheimer's ____________________

❑ Other ____________________

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GLOBAL STATUS:

Have you ever been bitten by a tick? ❑ Yes ❑ No ______
Are there mold issues in your living environment? ______ ❑ Yes ❑ No ❑ Current ❑ Past
Antibiotic use? ❑ Yes ❑ No ❑ Current ❑ Past
How is your appetite? ❑ Low ❑ Medium ❑ High Favorite Food? ______
Energy Level? ❑ Low ❑ Medium ❑ High ______
How do you rate your stress level?
❑ Low ❑ Medium ❑ High
Stressors: ❑ Family ❑ Work ❑ Environment ❑ Financial
❑ Other ______
Sleep: Hours ______ Quality ______
Interruption: ❑ Dreams ❑ Urinating ❑ Night Pain ❑ Eating ❑ Other ______
Any: ❑ Fatigue ❑ Lack of Motivation ❑ Sudden Weight Gain or Loss?
Have you ever traveled outside the US?
If so, where? ______ When? ______
Have you ever been exposed to second hand smoke? ❑ Current ❑ Past ______
Any: ❑ Scars ❑ Tattoos ❑ Lesions on your body? ______
Any form of an eating disorder? ❑ Binging ❑ Purging ❑ Overeating ______
Do you feel you have purpose and meaning in life? ❑ Yes ❑ No

SYSTEMS EVALUATION:

Do you feel you are having any cognitive issues?
❑ Memory ❑ Concentration ❑ Coordination of thoughts
❑ Name Recall ❑ Number Recall ❑ Other ______
Any balance issues? ❑ Trip ❑ Falls ❑ Stumbles ❑ Shuffle ❑ Weakness
❑ Other ______
Any weakness in your: ❑ Body ❑ Arms ❑ Legs ❑ Hands ❑ Feet
❑ Other ______
Any: ❑ Tingling ❑ Numbness ❑ Pins & Needles ❑ Neuropathy
❑ Other ______
Do you have headaches?
❑ Yes ❑ No
Location: ______ Describe: ______
Any recent changes with your hair? ❑ Yes ❑ No ______
❑ Loss ❑ Thinning ❑ Color ❑ Texture ❑ More Oily ❑ More Dry
Eye Concerns: ❑ Yes ❑ No ______
Ear Concerns: ❑ Yes ❑ No ______
❑ Discharge ❑ Loss ❑ Pain ❑ Wax ❑ Ringing ❑ Other ______
Sinus/Nasal: ❑ Discharge ❑ Pain ❑ Infection ❑ Tender ❑ Allergies
❑ Other ______

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Oral:
Teeth: ❑ Cavities ❑ Caps ❑ Fillings ❑ Other ______
Hygiene: ❑ Floss ❑ Brush ❑ Cleanings
❑ Sores ❑ Ulcers ❑ Lesions ❑ Dry mouth ❑ Thirst
❑ Other ______
Tongue: ❑ Taste loss ❑ Swelling ❑ Cracking ❑ Halitosis ❑ Canker ❑ Coated
Throat: ❑ Difficulty swallowing ❑ Sore ❑ Swelling ❑ Other ______

Breast: ❑ Tenderness ❑ Lumps ❑ Discharge ❑ Cancer ❑ Cysts
❑ Discoloration
❑ Mammogram ❑ Breastfeeding / Other ______
Chest: ❑ Lung pain / LOP ______ ❑ Difficulty breathing ❑ Wheezing
Shortness of breath: ❑ At rest ❑ With exertion ❑ Other ______
Cardiovascular: ❑ Pain / LOP ______ ❑ Murmur ❑ Arm pain
❑ Blood pressure ______ ❑ Cold hands or feet ❑ Cramping
❑ Clots ______ ❑ Varicose veins
❑ Pacemaker ❑ Defib ❑ Surgery ______
Stomach: ❑ Pain ❑ Reflux ❑ GERD ❑ Nausea ❑ Vomiting
❑ Ulcers: ❑ Past ❑ Present ❑ Bloating
❑ Hiatal Hernia ❑ Belching ❑ Gas ❑ Aggravating foods ______
Liver/Gall Bladder: ❑ Tenderness ❑ Pain ❑ Surgeries ______
❑ Swelling ❑ Fatty foods
Pancreas: ❑ Tenderness ❑ Pain ❑ Hypo ❑ Hyper ❑ Diabetes ❑ LOP ______
Bowel: ❑ Pain ❑ Distention ❑ Constipation ❑ Frequency ______ x per day/week
Color: ❑ Dark ❑ Light ❑ Clay
Consistency: ❑ Hard ❑ Pebbles ❑ Diarrhea ❑ Soft ❑ Other ______
Recent Colonoscopy: ______ ❑ IBS ❑ Crohn's ❑ Polyps ❑ Diverticulitis
Hemorrhoids: **Surgery** ______
Genital:
Female:
Discharge ❑ Yes ❑ No With Ovulation ❑ Yes ❑ No
Frequency ______
Color: ❑ Blood ❑ Clear ❑ Yellow ❑ Green ❑ Other ______
❑ Odor ❑ Yeast infections ❑ Current ❑ Past ❑ C-sections ______
Hysterectomy: ❑ Partial ❑ Complete ❑ Other ______
Last Menstrual Period: ______ Duration ______ days
Frequency ______
❑ HRT ❑ Facial hair ❑ Fibroids ❑ Cysts ❑ Endometriosis
PMS: ❑ Depression ❑ Irritability ❑ Fatigue ❑ Acne ❑ DNC's ❑ Libido

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