

WELCOME TO OUR OFFICE

Confidential Patient Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): (____) _____ (Work): (____) _____ (Mobile): (____) _____

Email: _____ Referred By: _____

Age: _____ Birth Date: _____ Social Security No: _____ Sex: M / F Marital Status: S / M / W / D

Occupation: _____ Employer & Address: _____

Spouse's Name: _____ Spouse's Work Phone: (____) _____ Number of Children: _____

Emergency Contact: _____ Contact Phone: (____) _____

Date of Last Physical Exam: _____ With Whom: _____ Where: _____

Reported Findings: _____

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): _____

Fractures, Dislocations, Major Dental Work (List Year in Brackets): _____

Conditions You Have Had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sinus Troubles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis / Joint Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Numbness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Parasites | <input type="checkbox"/> Urinary Trouble |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Yeast / Candida |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever | _____ |

Purpose of This Appointment: _____

Other Doctors Seen For This Condition: _____

Have You Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe): _____

Medications / Drugs You Are Taking (state reason in brackets following drug): _____

Remarks / Additional Information: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of Person Responsible for Payment: _____

Address & Phone (if different than yours): _____

PATIENT AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation.

Signature: _____ Parent / Guardian Signature: _____ Date: _____

ADDITIONAL INFORMATION:

Height: _____ Weight: (Now) _____ (One Yr. Ago) _____ (Adult Maximum) _____ Age _____ (Adult Minimum) _____ Age _____
 Known Allergies: _____

Blood Type: _____ Have You Ever Had a Blood or Plasma Transfusion? Yes / No

Habits:
 Do You Smoke? Y / N What? _____ How Many / Day: _____ Since When? _____
 Other Tobacco Products? Y / N What? _____ How Many / Day: _____ Since When? _____
 Drink Coffee? Y / N Cups / Day _____ Drink Caffeinated Tea? Y / N Cups / Day _____
 Colas / Soft Drinks? Y / N Number / Day _____ Glasses of Water / Day: _____
 Alcoholic Beverages? Y / N Avg. No. / Wk _____ Mostly What? _____
 Do You Eat Red Meat? Y / N Are You a Vegetarian? Y / N If So, For How Long? _____
 Are You Dieting? Y / N If So, Describe: _____
 Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week: _____
 List Nutritional Supplements You Take: _____

Bowel Movement Frequency: _____ Difficulty? Y / N Approximate Number of Times You Urinate / Day: _____
 Do You Sleep Well? Y / N If No, Describe: _____ Average Hours / Night: _____
 Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe: _____

Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right: _____ / 20 Left: _____ / 20
 Has Your Vision Changed Recently? Y / N Explain: _____
 Do You Wear Heel Lifts or Foot Supports? Y / N Explain: _____

Exercise:
 What Sports Have You Played Seriously? _____
 What Sports Do You Enjoy Now? _____
 Are You In Training For a Particular Sport? Y / N Describe: _____
 Do You Use a Heart Rate Monitor? Y / N If So, Target Range: _____
 Describe Your Exercise Program: _____

XRAY HISTORY: (Include CAT, MRI, dye studies and dental) When was most recent x-ray / other study performed?

Age	Body Area	Type (Normal X-ray, CAT, MRI, etc.)	No. of Studies

FAMILY HISTORY:

	Living?	Age or Age At Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Grandparents													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandparents													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset: _____ Are Your Periods Regular? Y / N Cycle: _____ days (start to finish) Use Birth Control Pill? Y / N
 Your Flow Is: heavy medium light Date of Last Period: _____ Cramping? Y / N
 PMS? Y / N If So, What: _____
 Other Menstrual / Hormonal Symptoms: _____