Contact Information			
First	Last	M.I	Preferred

Current Date	Date of Birth	Gender

Street	City

State	Zip	email

Cell	Home	Text? Y N Voice Messages? Y N Email? Y N

Occupation:	Who may we thank for referring you?

Emergency Contact Information		
Name	Relation	Phone

Street	City

State	Zip	

What brought you in today?

____

____

____

____

____

____

Medical History: Please Circle all that apply

General	**Nose Throat Mouth**	**Gastrointestinal**	Heart Failure
Irritability	Sinus Infections	Nausea	Cardiovascular Disease
Depression/Anxiety	Hay Fever / Allergies	Indigestion	Heart attack
Insomia	Frequent Sore Throat	Stomach Pain	**Respiratory**
Dreams/Nightmares	Difficulty Swallowing	Diarrhea	Difficulty Breathing
Mood Swings	Ulcers	Constipation	with exertion
Fatigue	Frequent Colds	Poor Appetite	when laying down
Poor Memory	Nose Bleed	Excessive hunger	Wheezing
Strong dislike of cold	Nasal Congestion	Vomiting	Asthma
Strong dislike of heat	Dry nose/ Dry Throat	Gas	Emphysema/COPD
Recent weight gain/loss	Loss of Voice	Hiccups	Chronic Cough
Cold hands and feet	Increased Thirst	Acid Regurgitation	Wet Cough
Chills	Decreased Thirst	Bloating	Dry Cough
Fever	Excessive mucus	Bad Breath	Coughing mucus
Head and Neck	TMJ	Laxative Use	Coughing Blood
Headaches	Gum Problems	Bloody stool	Short of Breath
Migraines	Dry Mouth	Mucus in Stool	Chest Tight
Stiff neck	**Skin**	Hemorrhoids	Pneumonia
Dizziness	Hives	**Cardiovascular**	**Musculoskeletal**
Fainting	Rashes	High Blood Pressure	Joint pain/disorder
Swollen glands	Excema	Low Blood Pressure	Sore Muscles
Ears	Psoriasis	Chest Pain	Weak Muscles
Ringing	Night Sweats	Chest pressure	Difficulty walking
Hearing Loss	Dry skin	Palpitations	Balance issues
Infections	Easy Bruising	Rapid Heart Rate	Neck pain
Earache	Changes in Moles	Irregular heart Beat	Upper back Pain
Hearing aids	Lumps	Poor Circulation	Lower Back Pain
Vertigo	Acne	Swollen Ankles	Rib pain
Pain	Itching	Phlebitis	Limited Range of motion
	Poor wound Healing	Anemia	Other (describe)

Neurological	Genito/Urinary	Infection Screening	Diabetes
Seiziure	Pain with Urination	HIV	Kidney disease
Tremor	Frequent Urination	Hepatitis	Multiple sclerosis
Stroke	Urgent Urination	TB self or household	Osteoporosis
Pain	Blood in Urine	History STD	Siatica
Numbness	Unable to Hold Urine	Gonorrhea	Scoliosis
Tingling	Incomplete Urination	Chalamydia	Seizures
Poor Cordination	Bed wetting	Syphillis	Sleep apnea
Paralysis	Wake to Urinate	Genital Warts	Thyroid disease
Chronic Fatigue	Kidney Stones	HPV	Bipolar Disorder
Fibromyagia	Kidney infections	Oral Herpes	Schizophrenia
Bells Palzy	Urinary Tract Infections	Genital Herpes	PTSD
Eyes	Impotence	**Other Diseases**	**Diseases not Listed**
Poor Night Vision	Decreased Libido	Alzheimers	
Floaters	Increase Libido	Auto immune	
Dry Eyes	Premature Ejaculation	Blood clots	
Reduced Sight	Nocturnal Emission	Chrons	
Macular Degeneration	Pain/Itching Genitalia	Ulcerative colitis	
Glaucoma	Lumps in testicles	Cancer	

Please list any surgeries or hospital stays you have had and their approximate date year:

____ ____________________

Surgery/Reason For Hospital Stay Date

____ ____________________

Surgery/Reason For Hospital Stay Date

____ ____________________

Surgery/Reason For Hospital Stay Date

____ ____________________

Surgery/Reason For Hospital Stay Date

Please list any serious medical issues, injuries or illnesses not listed above:

____

INJURIES

Please list any current or past injuries: ____

____

____

Who is your primary care Physician: Name ______________________Phone:______________

When was your last physical? ____

Do you have any other physicians or medical providers involved with you care? Please list

Provider name | What are you seeking care for

________________________________ ____

________________________________ ____

________________________________ ____

________________________________ ____

May we discuss your care with the above health care practitioners? Yes / No Yes but only the ones that I have circled above.

If you have had any of the following tests, note approximate date and the results, if known.

Test	Date	Results
Colonoscopy		
Hepatitis C/B		
HIV		
Mamogram		
Pap smear		
Prostate Exam		
Cholesterol		
Blood Sugar Hemoglobin A1C		
Tuberculosis		

Please list any known allergies and reactions to food or drugs or latex:

____

____

____

Medication	Dose	TAKEN FOR

Please list any additional medications that wont fit in the above column here with their doses and uses: ____

____

____

____

Supplements / Herbs / Vitamins: ____

____

____

____

PERSONAL LIFESTYLE HABITS:

Cigarettes: daily:________ Coffee/Tea: Cups daily__________

Alcohol daily:__________________ Alcohol Weekly______________

Marijuana: ________________ Other recreational drugs: ________________________

DIET

Dietary restrictions: ______________________________

Food cravings: ______________________________

What might you eat on a typical day?

Breakfast	Dinner
Lunch	Snacks

EXERCISE & ACTIVITY LEVEL

Type of Exercise: ______________________________

____

Level of Activity: (Sedentary/Light/Moderate/Extreme) ______________________________

____

What non-work activities or hobbies do you enjoy doing? (reading, TV, meditation, music, etc.)

____

____

____

Do you have a religious Preference if so what is it?

____

____

____

STRESS

*Please provide any information you feel comfortable sharing:

What stressors (if any) concern you in your day to day life, and would you like to address them in treatment:

____

____

____

____

FAMILY MEDICAL HISTORY

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	CHILDREN
Alcohol or Drugs									
Cancer									
Heart Disease									
High Cholesterol									
Neurological Disorder									
Psychological Disorder									
Stroke									
Age of Death									
Other									

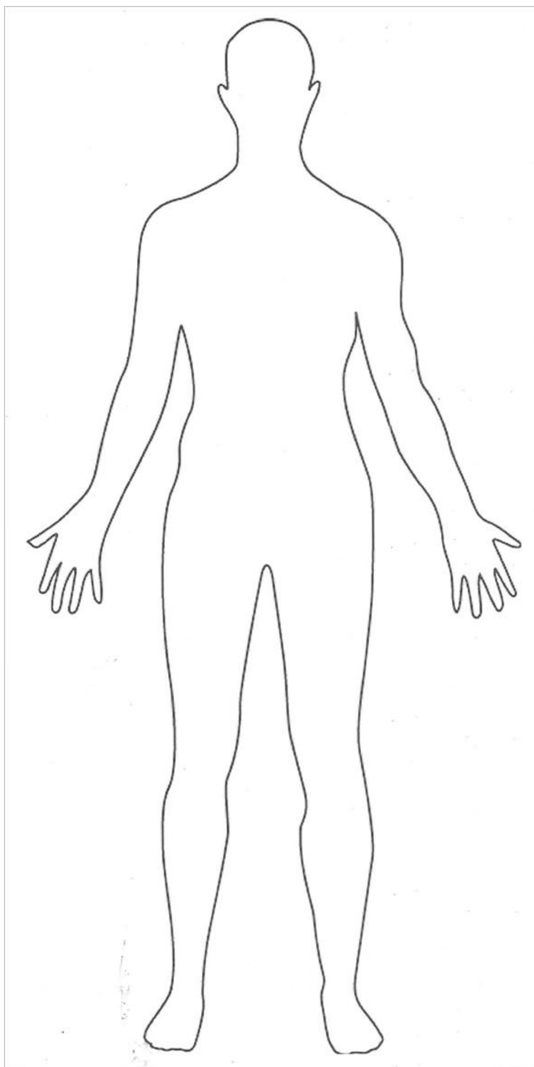
PAIN: Scale: How would you rate your overall pain on a scale of 1-10 ________

Please Circle and Describe your pain at its location by the following letters:
A: Aching **B**: Burning **S**: Shooting **N**: Numbness **D**: Dull **I**: Intermittent **C**: Constant

If you have pain please include pain scale next to your location: 1-10

Right Left Right Left

Front



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