Patient's Reason for Visit

Patient's Name _____ Date _____

Please check the main health benefits/improvements you, or your child, would like to achieve…

Relaxation__ Improved Sleep__ Stronger Immunity__ Allergy Relief__ Increased Energy__
Increased Circulation__ Headache Relief__ Pain Relief__ Injury Rehabilitation__ Scar Tissue__
Better Mobility/Flexibility__ Physical Fitness__ Better Outlook on Life/Emotional Freedom__
Other_____

If there is a PAIN or DYSFUNCTION complaint, please answer the following questions…

Briefly explain your (or your child's) health issue: _____
_____
_____
_____

When did you first notice this issue? _____
_____

Describe the symptoms: _____
_____
_____

If there is pain…

Where is it located? _____
_____
How often do you feel it? _____
Is the pain in one specific area, or does it radiate to different locations? _____
_____
Does it keep you up at night? _____
Rate your pain from 0-1-2-3-4-5 ("0" being no pain, "5" being extreme pain): _____

What do you believe is the cause of this issue? _____
_____

Have you received a doctor's diagnosis? _____
_____

What treatments have you already received or tried? _____
_____

List any medications or supplements you are taking for this issue: _____
_____

List anything that is helping, or has helped with this problem: _____
_____

Is there anything else I should know about? _____
_____
_____