APPLICATION FOR CONSULTATION/EXAMINATION

Personal Information

Name: _____ Today's Date: _____/_____/_____

Address: _____City, State_____ Zip_____

E-Mail Address: _____

Birth Date: _____/_____/_____ Age: _____ Male ____ Female____
If Female, Are You Pregnant: __Yes __No

Spouse/Partners Name _____

Occupation: _____

Cell Phone No.: _____ Home Phone No.: _____

How Were You Referred To Our Office?: _____

Current Health Condition

In order of importance, list the health problems you are most interested in getting corrected.

1. _____
2. _____
3. _____
4. _____
5. _____

Date of Onset of Symptoms _____

Please check if you have the following symptoms:

__HEADACHES
__NECK PAIN
__SLEEPING PROBLEMS
__BACK PAIN
__ANXIETY
__TENSION
__IRRITABILITY
__LOSS OF MEMORY
__EARS RING
__NECK STIFF
__FOOT PAIN
__HIP PAIN
__WRIST PAIN

__PINS AND NEEDLES IN LEGS
__NUMBNESS IN FINGERS
__NUMBNESS IN TOES
__SHORTNESS OF BREATH
__FATIGUE
__DEPRESSION
__LIGHTS BOTHER EYES
__COLD SWEATS
__LOSS OF BALANCE
__FAINTING
__ANKLE PAIN
__SHOULDER PAIN
__JAW PAIN

__LOSS OF SMELL
__LOSS OF TASTE
__DIGESTIVE PROBLEMS
__FEET COLD
__HANDS COLD
__STOMACH UPSET
__CHEST PAINS
__DIZZINESS
__FEVER
__LOW ENERGY
__KNEE PAIN
__ELBOW PAIN
__ALLERGIES

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

_____

_____

Has your health problem been: __Improving __Worsening __Staying the Same

Please describe anything you do that improves your condition, or worsens it:

_____

Please describe how this problem interferes with your work and/or personal life:

Home Activities Affected:_____

Work Activities Affected: _____

Recreational Activities Affected: _____

Rest or Sleep Affected: _____

If you didn't know your age, how old do you feel?: _____

Previous Health History

During the last year, has a doctor treated you for any health problem? __Yes __No
If yes, please explain:

Please check the drugs you are now taking: __Pain Killers __Muscle Relaxers __Anti-inflammatory

__Blood Pressure Drugs __Cholesterol Drugs __ Insulin __Birth Control Pills __Diet Pills

__Nerve Medication __Sleeping Pills __Depression Drugs __Other

Do you Smoke? __Yes __No Do you drink alcohol? __Yes __No__Socially

Do you have a pacemaker? __Yes __No

Do you have a root canal? __Yes __No

Do you have amalgam (silver) fillings? __Yes __No

Has your home ever had any water damage? __ Yes __ No

Are you currently living in mold (or have you lived in mold in the past? __ Yes __ No

Please circle if you take any of the following supplements: __Fish oil __Vitamin D3 __Probiotics

OTHER_____

List the approximately dates of any operations or serious injuries (including broken bones) you have had:

_____

_____

Thank you for helping the doctor with your health information!

If you would like the Doctor and Staff to pray for you (Christian), there is a prayer request box in the waiting room. Your requests will remain confidential.