Name ..... Date .....

Address ..... Phone # .....

City ..... State ..... Zip ..... Email.....

Emergency Contact ..... Contact Phone # .....

Occupation ..... Employer ..... Address .....

Whom can we thank for referring you? .....

Age ..... Birth Date ..... Height ..... Weight ..... Marital Status .....

Reason for seeking treatment? .....

How long have you had this condition? ..... Severity 1 2 3 4 5 6 7 8 9 10 .....

Condition is getting: ☐ BETTER ☐ WORSE ☐ SAME ☐ COMES & GOES

Other physicians seen for treatment? .....

Physician Phone # ..... Diagnosis? .....

List any surgical operations ..... Date: .....

..... Date: .....

..... Date: .....

List any medications you are taking:..... For ..... Since .....

(condition below of necessary) ....

....

List any over the counter medications or supplements and reasons for taking : .....

.....

.....

List any other conditions of concern to you: .....

.....

.....

Last Menstrual Period ..... Are you pregnant? ☐ YES ☐ NO

Do you experience any of the following symptoms: (√) occasionally (+) frequently (*) right now

- stomach pain	- high blood pressure	- asthma/ short breath	- liver disorder	- urinary prob
- lack of appetite	- chest pain	- cough	- gallstones	- low back pain
- excess appetite	- heart palpitations	- sinus problems	- eye irritation	- knee problems
- diarrhea/loose stool	- anxiety/ depression	- constipation	- easily angered	- ear ringing
- indigestion	- nightmares	- skin disorders	- soft/brittle nails	- hair loss
- heartburn/acid reflux	- insomnia, diff sleep	- hemorrhoids	- muscle spasms	- low sex drive
- nausea/ vomiting	- dizziness	- allergies	- painful menses	- edema
- fatigue after eating	- headaches	- nose bleeds	- rib-side pain	- feel cold
- bad breath	- diff concentrating	- phlegm	- bitter taste in mouth	- brittle bones
- poor healing wounds	- easily tired	- easily catch cold	- bleeding disorders	- infertility
- cancer	- stroke	- tuberculosis	- hepatitis	- HIV/ AIDS

I understand that this questionnaire and all inquiries about my health are completely confidential and any information obtained is only to be used to best evaluate my health and treatments. I also understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at time of services rendered.

Patient's Signature ..... Date.....