All information entered will be kept confidential in your file according to HIPPAA regulations.

Name: Birth Date: / /

(if Veteran) SSN: - -

Address:

City: State: Zip:

Preferred Phone: ( ) - email:

Secondary Phone: ( ) - may we email you special offers? Y N

Occupation: how did you hear about us?

In Case of Emergency Contact:

Phone: Relationship:

Are you being treated elsewhere?

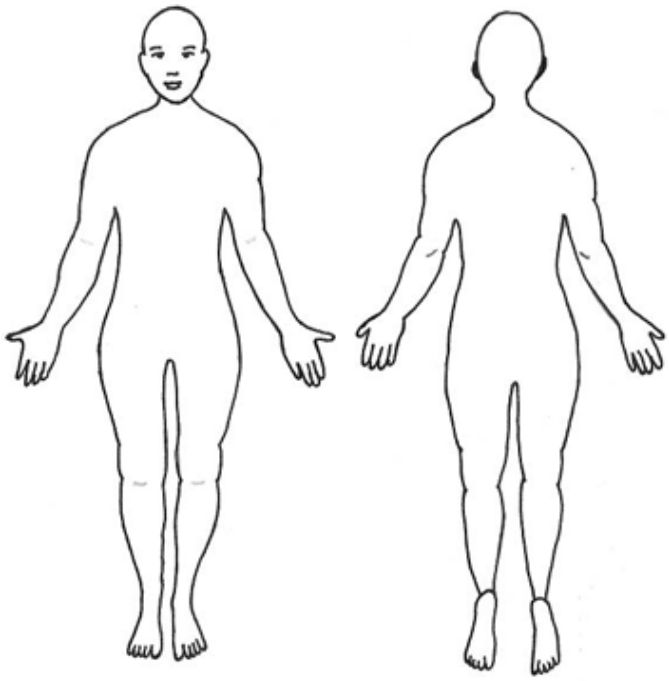
Current medications, supplements, vitamins:

Primary concern you would like addressed:

Medical History: Mark with C for current or P for past			
___ arthritis	___ bleeding tendency	___ cancer	___ headaches
___ allergies	___ high blood pressure	___ chronic fatigue	___ heart disease
___ anemia	___ low blood pressure	___ diabetes	___ hepatitis
___ continual hunger	___ COPD	___ BPH/ prostate issue	___ PTSD
___ asthma	___ bronchitis	___ digestive issues	___ HIV
___ insomnia	___ infertility	___ irregular menses	___ depression
___ anxiety	___ depression	___ infections	___ thyroid issues

Lifestyle: Mark with "C" for current or "P" for past		
___ Alcohol	___ Recreational Drugs	___ Exercise
___ Tobacco	___ Birth Control Pills	___ Meditation
___ Caffeine	___ Special Diet	___ Vitamins/Supplements
___ Stress level (rate 1-10)	___	

Mark area of pain along with severity (1-10)



Mark any that currently apply	
___ Sudden ___ New ___ Constant ___ Sharp ___ Tingling ___ Numbness ___ Spasm/Tremor ___ Pain is only when_____	___ Gradual ___ Old ___ Chronic ___ Intermittent ___ Dull ___ Burning ___ Radiates from _____ to _____

Review of Systems- circle any that apply	
Mood	Normal Sad Happy Stressed Angry Depressed Vacillating
Energy	Normal Low Excessive Low after eating
Sleep	Normal (___ hours) Awake rested Awake Tired
Thirst	Desire cold Desire hot No thirst Unquenchable thirst Thirst w/o desire to drink
Appetite	Normal Increased Decreased Ravenous Craving_____
Diet	Vegetarian Vegan "Normal" Special_____
Digestion	Gas Hiccups Belching Reflux Bad Breath Nausea Vomit Full/Bloating
Bowels	Healthy (how often?_____) Diarrhea Constipation Other_____
Urine	Normal Dark Bloody Burning Cloudy Wake to urinate (how many times___)

Women		
Date of last menses:	___ long cycle ___ irregular	___ short cycle ___ currently on hormonal BC
Amount:	___ heavy	___ scanty
Color:	___ pale ___ bright red ___ cloudy	___ brown ___ dark red ___ clotted
Vaginal Discharge	___ white ___ green ___ brown	___ yellow ___ strong smelling ___ other
History	___ PID ___ STD ___ Cysts	___ endometriosis ___ surgery ___ other
Pregnancies (#): ___	___ (#) abortions ___ complications	___ (#) births ___ vaginal or ___ C-section
IVF: **date:**	___ (#) IVF attempted ___ IUI attmepted	___ (#) eggs harvested ___ how many will be transferred? ___
Libido:	___ normal ___ dryness with intercourse ___ pain with intercourse	___ low ___ high