



PATIENT INFORMATION

Name: _____

Street Address: _____ City: _____

State/Zip: _____ Phone _____

Email: _____ Birth date: ____ - ____ - ____

Emergency contact: _____ Phone: _____

HEALTH INFORMATION

Health concerns: _____

CHECK ALL SYMPTOMS YOU HAVE NOTICED:

- | | | | | |
|--|---|---|--|--------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> fainting | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> depression | <input type="checkbox"/> loss of smell | <input type="checkbox"/> fever |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> light bothers eyes | <input type="checkbox"/> loss of taste | |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> pins & needles in arms | <input type="checkbox"/> loss of memory | <input type="checkbox"/> diarrhea | |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> pins & needles in legs | <input type="checkbox"/> ears ring | <input type="checkbox"/> feet cold | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> face flushed | <input type="checkbox"/> hands cold | |
| <input type="checkbox"/> Tension | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> buzzing ears | <input type="checkbox"/> stomach upset | |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> loss of balance | <input type="checkbox"/> constipation | |

Other Symptom: _____

Have you ever had same or similar symptoms? No Yes If yes, describe when: _____

Have you seen another doctor for this condition? No Yes If yes, Doctor's name: _____

Treatment received: _____ Are you pregnant? No Yes

What medications/supplements are you presently taking? _____

Surgeries: _____

Have you or anyone in your immediate family had (or have) any of the following conditions (check all that apply):

- | | | | | | |
|------------------------------------|-----------------------------------|--|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Back Pain |

REFERRAL INFORMATION

How did you find out about me?

or

Whom may I thank for referring you ? _____

Health Goals

What would make our work together a success for you?

Rate your satisfaction in the following areas. (1-10 with 10 being fabulous)

Family and relationships: _____ social network _____

Physical health _____ Career/job _____

Spiritual _____ Financial _____

Emotional _____

How many hours of sleep do you average per night? _____

Rate the quality of your sleep. (1-10) _____

What are the things you regularly do to support your health and happiness?
(exercise, knit, meditate, go out with friends, cook)

AUTHORIZATIONS

I understand and agree that (regardless of my insurance carrier), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed all the above answers. I certify that it is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient's Signature: _____ Date: _____