Patient Information Form

Please Print Clearly. Please complete ALL information on this form (3 PAGES).

Please help us to spell your name correctly by block printing it!

Today's Date:_____/_____/_____

PERSONAL INFORMATION

First Name _____Middle Initial_____ Last Name_____
Mr., Mrs., Ms., Dr., Etc. Called (Nick) Name_____
Address _____ Apt.#_____
City _____State____ Zip_____
Home Phone _____Work Phone _____ Ext _____ _____
Cell / Mobile Phone _____ Pager _____ Fax _____
E-mail _____Phone number for appointment reminders _____
Birth date _____ Age _____ Sex: Male Female Height_____ Weight_____
Occupation _____ Employer _____
If patient is a minor, parent / guardian name(s): _____
Emergency Contact Name Phone _____
Referred By (how did you hear about us?): _____

FINANCIAL INFORMATION

Person responsible for payment Self /Other If other: Name (We do not file insurance)
Method of Payment Cash /Check

HISTORY

List any major illnesses with approx. dates _____
_____
List any surgery or operations with approx. dates_____
_____
Past accidents, injuries or falls with approx. dates_____
_____

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation, solvents or heavy
metals? No Yes If yes, explain
Do you have, or have you ever had, “silver” fillings in your teeth? No/Yes
Root canal(s)? No/Yes
Have you had tooth extractions? No/Yes Are you currently having any trouble with your teeth? No/Yes

WOMEN ONLY: MENSTRUAL HISTORY

Date Of Last Menstrual Period _____ Age at first onset_____
Are your periods regular? No Yes If not, explain _____
Do you experience cramping? No Slight Moderate Severe
Do you have any PMS symptoms? No/Yes
If so, what? _____
Are you currently pregnant? No/Yes Are you currently using birth control? No/Yes What?

FAMILY HISTORY

Marital Status: S/M/W Name of spouse_____

Describe health of spouse _____

Number of Children, if any _____

Name of Child	**Age**	**Sex**	**Any physical conditions or concerns?**
_____	___	M / F	_____
_____	___	M / F	_____
_____	___	M / F	_____
_____	___	M / F	_____

Any family history of serious illnesses? Cancer Diabetes Heart Other_____

PRESENT COMPLAINTS

List below the four main health complaints you have in order of their importance to you (List the problem you would most like to get rid of below as # 1, then the second "worst" problem as # 2, etc.):

1. _____

First began how long ago? _____How often does this bother you?_____

What treatments have you tried?_____

_____

Has this problem been getting better, worse or staying the same? _____

2. . _____

First began how long ago? _____ How often does this bother you? _____

What treatments have you tried? _____

_____

Has this problem been getting better, worse or staying the same? _____

3. . _____

First began how long ago? _____How often does this bother you? _____

What treatments have you tried? _____

_____

Has this problem been getting better, worse or staying the same? _____

4. . _____

First began how long ago? _____How often does this bother you? _____

What treatments have you tried? _____

_____

Has this problem been getting better, worse or staying the same? _____

OTHER COMPLAINTS OR PROBLEMS: (use separate sheet if needed)

_____ _____

_____

_____

What is your present weight? _____What is your ideal weight? _____

What time of day are you most tired? _____

Do you get depression, worry, lack of concentration or memory problems? Please explain:
_____
_____
Number of bowel movements: ___ x per day every other day every _____ days _____ x per week
List any allergies or foods / substances you are sensitive to: _____

DRUGS, MEDICATIONS, SUPPLEMENTS
Current **medications/drugs** being taken, including "over the counter" medications: (use a separate sheet if needed):
Drug: _____Taken For: _____How Long? _____How Often? _____
Drug: _____Taken For: _____How Long? _____How Often? _____
Drug: _____Taken For: _____How Long? _____How Often? _____
Drug: _____Taken For: _____How Long? _____How Often? _____
Drug: _____Taken For: _____How Long? _____How Often? _____
Drug: _____Taken For: _____How Long? _____How Often? _____
Drug: _____Taken For: _____How Long? _____How Often? _____
Are you currently under the care of a physician or other health care professionals? No/Yes
If Yes, Doctor's name _____Date of last visit_____

Any **nutritional supplements** (vitamins), herbs, tonics or other remedies you are taking_____
_____

DIET AND LIFESTYLE:
HOW MUCH OF THE FOLLOWING DO YOU CONSUME PER WEEK? If you used to do this, write "past".
Coffee (sugar? milk?) _____
Alcohol _____
Cigarettes_____
Diet Soda _____
Artificial sweeteners_____
Tea (sweet / unsweet?) _____
Chocolate_____
Laxatives_____
Regular Soda_____
Recreational Drugs_____
Hobbies / activities you enjoy_____
_____
MAJOR LIFE CHANGES: (example: divorce, losses, trauma, etc.)
_____
_____

Past and Current Diet Information
Give some examples of ***foods you eat currently:***:
Breakfast_____
Lunch_____
Snacks_____
Dinner_____
Liquids_____