

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?

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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? _____

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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?) _____

Tea (sweet / unsweet?) _____

Alcohol _____

Chocolate _____

Cigarettes _____

Laxatives _____

Diet Soda _____

Regular Soda _____

Artificial sweeteners _____

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 _____

