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Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Are you interested in receiving our E-newsletter? Y N

Are you currently receiving healthcare? Y N

If yes, where and from whom? \_\_\_\_\_

For what reason? \_\_\_\_\_

What health concerns have brought you here today (in order of importance to you)?

	Condition	Past Treatment
1.	_____	_____
2.	_____	_____

Do you have any reason to believe you're pregnant? Y N

Do you have any chronic infectious diseases? Y N If yes, please explain: \_\_\_\_\_

Do you currently suffer from any chronic illnesses? Y N If yes, please explain: \_\_\_\_\_

Please list any allergies or hypersensitivities (environmental, foods, medications): \_\_\_\_\_

Please list all prescribed medications, over-the-counter medications, vitamin supplements, mineral supplements or herbal supplements that you are currently taking: \_\_\_\_\_

Height: \_\_\_\_\_ Weight (current): \_\_\_\_\_ Weight (past maximum): \_\_\_\_\_ When? \_\_\_\_\_

What was your most recent blood pressure reading? \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

**Hospitalizations and Surgeries:**

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

**X-Rays/CT Scans/MRIs/Special Studies:**

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

Reason: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Family History:</b>	Mother	Father	Brothers	Sisters	Spouse	Children
Age: (if living, or at death)						
Health: (G=Good, P=Poor)						
Cause of death: (if deceased)						
Check any conditions below that the above family members have had:						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						

Please check the box for symptoms below that you have experienced in the past year:

<p><b>Head, Eyes, Ears, Nose and Throat:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Impaired Vision</li> <li><input type="checkbox"/> Eye Pain/Strain</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Tearing/Dryness</li> <li><input type="checkbox"/> Hay Fever</li> <li><input type="checkbox"/> Impaired Hearing</li> <li><input type="checkbox"/> Ear Ringing</li> <li><input type="checkbox"/> Earaches</li> <li><input type="checkbox"/> Sinus Problems</li> <li><input type="checkbox"/> Nose Bleeds</li> <li><input type="checkbox"/> Frequent Sore Throat</li> <li><input type="checkbox"/> Teeth Grinding</li> <li><input type="checkbox"/> TMJ/Jaw Problems</li> <li><input type="checkbox"/> Other? _____</li> </ul>	<p><b>Gastrointestinal:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Changes in Appetite</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Stomach Pain</li> <li><input type="checkbox"/> Passing Gas</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Belching</li> <li><input type="checkbox"/> Gall Bladder Disease</li> <li><input type="checkbox"/> Liver Disease</li> <li><input type="checkbox"/> Hepatitis B or C</li> <li><input type="checkbox"/> Abdominal Pain</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Other? _____</li> </ul>	<p><b>Cardiovascular:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Heart Disease</li> <li><input type="checkbox"/> Heart Murmur</li> <li><input type="checkbox"/> Chest Pain</li> <li><input type="checkbox"/> Rheumatic Fever</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Palpitations/Fluttering</li> <li><input type="checkbox"/> Swelling of Ankles</li> <li><input type="checkbox"/> Varicose Veins</li> <li><input type="checkbox"/> Other? _____</li> </ul>
<p><b>Respiratory:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Persistent Cough</li> <li><input type="checkbox"/> Difficulty Breathing</li> <li><input type="checkbox"/> Frequent Common Colds</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Other? _____</li> </ul>	<p><b>Stools:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood in Stool</li> <li><input type="checkbox"/> Undigested Food</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Mucous</li> <li><input type="checkbox"/> Other? _____</li> </ul>	<p><b>Urinary:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney Disease</li> <li><input type="checkbox"/> Painful Urination</li> <li><input type="checkbox"/> Impaired Urination</li> <li><input type="checkbox"/> Frequent Urination</li> <li><input type="checkbox"/> Kidney Stones</li> <li><input type="checkbox"/> Blood in Urine</li> <li><input type="checkbox"/> Frequent Urinary Tract Infections</li> <li><input type="checkbox"/> Cloudy Urine</li> <li><input type="checkbox"/> Other? _____</li> </ul>
<p><b>Musculoskeletal:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Muscle Spasms/Cramps</li> <li><input type="checkbox"/> Neck Pain</li> <li><input type="checkbox"/> Shoulder Pain</li> <li><input type="checkbox"/> Upper Back Pain</li> <li><input type="checkbox"/> Mid Back Pain</li> <li><input type="checkbox"/> Lower Back Pain</li> <li><input type="checkbox"/> Arm Pain</li> <li><input type="checkbox"/> Leg Pain</li> <li><input type="checkbox"/> Other? _____</li> </ul>	<p><b>Neurological:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dizziness/Vertigo</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Numbness/Tingling</li> <li><input type="checkbox"/> Loss of Balance</li> <li><input type="checkbox"/> Seizures/Epilepsy</li> <li><input type="checkbox"/> Other? _____</li> </ul>	<p><b>Endocrine:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hypothyroidism</li> <li><input type="checkbox"/> Hyperthyroidism</li> <li><input type="checkbox"/> Hypoglycemia</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Night Sweats</li> <li><input type="checkbox"/> Feeling Hot or Cold</li> <li><input type="checkbox"/> Other? _____</li> </ul>

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b>Miscellaneous:</b></p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness <input type="checkbox"/> Mental Tension <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer <input type="checkbox"/> Rashes/Eczema/Hives <input type="checkbox"/> Cold Hands/Feet <input type="checkbox"/> Other? _____	<p><b>Male Reproductive:</b></p> <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Testicular Pain/Swelling <input type="checkbox"/> Penile Discharge <input type="checkbox"/> Sexually Transmitted Infections <input type="checkbox"/> Other? _____	<p><b>Female Reproductive:</b></p> <input type="checkbox"/> Irregular Cycles <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Breast Tenderness/Swelling <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Heavy Flow <input type="checkbox"/> Clotting <input type="checkbox"/> Premenstrual Symptoms <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> Difficulty Conceiving <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Sexually Transmitted Infections <input type="checkbox"/> Other? _____
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**Female Reproductive/Menstrual History:**

Age of first menses:	# of Pregnancies:	# of Miscarriages:
# of days of flow:	# of Live Births:	# of Abortions:
Length of cycle:	Birth Control:	

**Lifestyle:**

Diet: Are you (circle one): Vegetarian Vegan Omnivorous Other? \_\_\_\_\_

Fluid Intake (amount and type): \_\_\_\_\_

Exercise: \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you enjoy your work? Y N Why/Why Not? \_\_\_\_\_

Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

Have you experienced any major traumas? Y N Please explain: \_\_\_\_\_

**FINANCIAL POLICIES**

- Payment must be made at the time of service. Payment may be made in the form of cash, check, debit or credit card.
- A \$25 fee will be assessed for all returned checks.
- If you should need to reschedule or cancel an appointment, please do so at least 24 hours prior to your appointment time. If an appointment is cancelled within 24 hours or missed, please note that a \$30 missed appointment fee will be charged to your account.
- We may be able to bill your insurance company for your treatment. If we are unable to directly bill your insurance company, we will provide you with a receipt that contains all of the information needed by an insurance company to reimburse you.
- You are financially responsible for your account, regardless of insurance coverage. Accounts more than 30 days past due (after receipt of insurance payments, if applicable) will be assessed a 2% monthly fee.

I have read and understand the above financial policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_