## PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

How did you hear about this clinic: _____

Name of Medical Doctor: _____ Permission to contact for labs, etc. Y/N

## FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

| | |
|---|---|
| Cancer: | Autoimmune disease: |
| Eczema: | Arthritis: |
| Diabetes: | Allergies: |
| Heart disease: | Asthma: |
| High blood pressure: | Addictions: |
| Stroke: | Liver disease: |
| Thyroid disease: | Mental illness: |

List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

_____

Vaccinations: ❑ I have been fully vaccinated ❑ I get the flu shot regularly ❑ I have had some vaccines
❑ I haven't been vaccinated ❑ I have had travel vaccines (ie. Hepatitis) ❑ I don't know/don't remember

Successful health care and preventive medicine are only possible when I have a complete understanding of you – including your expectations and obstacles to cure. The nature of your responses to the following questions will go a long way in assisting how I can best help you. Your time, thoughtfulness and honesty in completing this overview are appreciated.

1. What expectations do you have from **this** visit to our clinic?

2. What expectations do you have **of me personally** as your health care provider?

3. What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Circle level of commitment:

   0% 1 2 3 4 5 6 7 8 9 10 (100%)

4. What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health?

5. What behaviors or lifestyle habits do you currently engage in regularly that you believe are **negatively impacting your health?**

6. What potential **obstacles** do you foresee in adhering to the therapeutic protocols that I will be sharing with you?

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description:

_____

Year: _____ Description:

_____

Year: _____ Description:

_____

Year: _____ Description:

_____

Please describe your overall level of stress:

_____

List any real or suspected allergies/sensitivities to drugs, food, alcohol, caffeine, chemicals, perfumes, smoke, environment, or other: _____

_____

Please list supplements you are currently taking:

1. _____ (Brand) (Supplement Name) (Daily Dose)
2. _____ (Brand) (Supplement Name) (Daily Dose)
3. _____ (Brand) (Supplement Name) (Daily Dose)
4. _____ (Brand) (Supplement Name) (Daily Dose)
5. _____ (Brand) (Supplement Name) (Daily Dose)
6. _____ (Brand) (Supplement Name) (Daily Dose)
7. _____ (Brand) (Supplement Name) (Daily Dose)
8. _____ (Brand) (Supplement Name) (Daily Dose)
9. _____ (Brand) (Supplement Name) (Daily Dose)
10. _____ (Brand) (Supplement Name) (Daily Dose)

Read the following questions and fill in the number that applies:

0 (leave blank) = Never consume or use
1 = Consume or use several times per month
2 = Consume or use weekly
3 = Consume or use daily

DIET

____ Alcohol
____ Artificial sweeteners
____ Candy or other sweets
____ Pop/soda
____ Chewing tobacco
____ Cigarettes
____ Cigars/pipes
8. _____ Coffee
9. _____ Fast food
10. _____ Fried foods
11. _____ Luncheon meats/hot dogs
12. _____ Margarine
13. _____ Milk/cheese/yogurt, etc.
14. _____ Non-herbal tea
15. _____ Refined flour/baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, tap
20. _____ Water, well
21. _____ Diet often (Y or N)

LIFESTYLE

_____ Exercise (3 = 5+ times per week, 2 = 2-4 times per week, 1 = once per week, 0 = none)
_____ Stress (3 = heavy/chronic, 2 = moderate/often stressed, 1 = light/occasionally stressed, 0 = none)
_____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1 = within last 12 months)
_____ Divorced (3 = within last 6 months, 2 = within last year, 1 = within last 2 years, 0 = never)
_____ Work over 40 hours/week (3 = always, 2 = usually, 1 = occasionally, 0 = never)

MEDICATIONS

Indicate with a check mark any medications you're currently taking or have taken in the past month:

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin/Ibuprofen
_____ Asthma inhalers
_____ Beta blockers
_____ Birth control
_____ Chemotherapy
_____ Cortisone
_____ Diabetic medications
_____ Diuretics
_____ Heart medications
_____ High blood pressure
_____ Hormone Therapy
_____ Laxatives
_____ Insulin
_____ Recreational drugs
_____ Relaxants/Sleeping pills
_____ Thyroid medication
_____ Tylenol/acetaminophen
_____ Ulcer medications
OOther: _____

Please list all current medications, dose, and how often you take them:

_____
_____
_____
_____
_____

## MAIN HEALTH CONCERNS

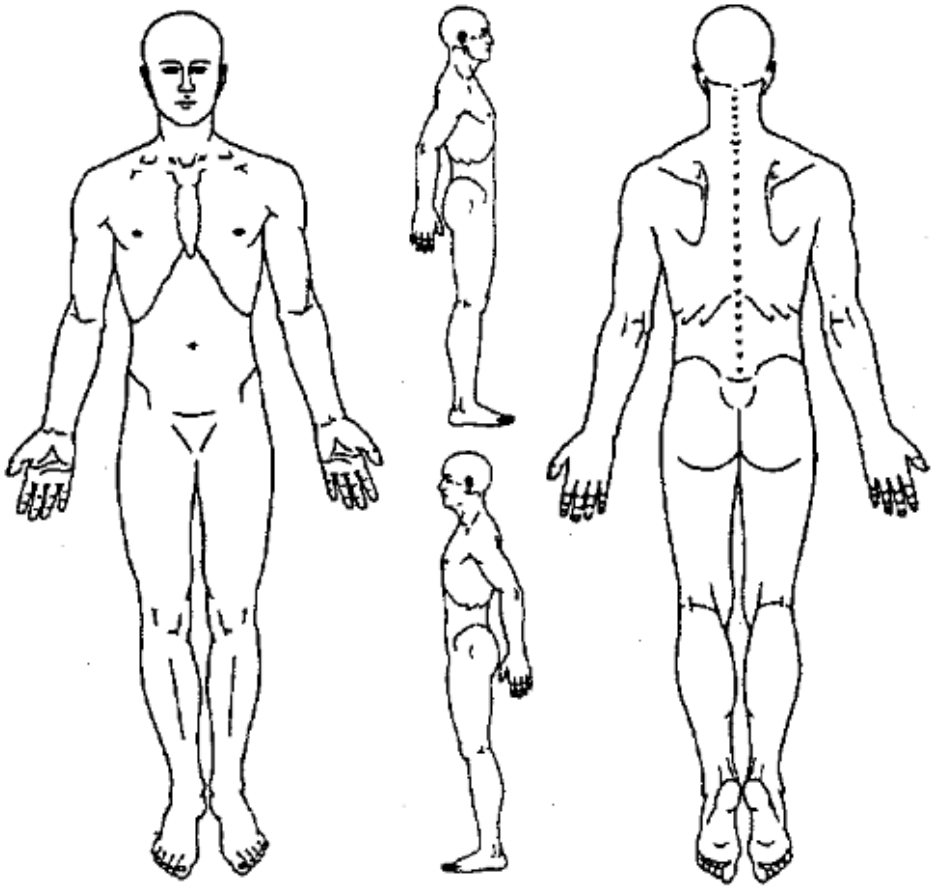
My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list, in order of importance, your chief concerns and their date of onset (DOS):

| Concern | DOS | Concern | DOS |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

Please indicate on the diagram below the location and quality of pain:

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - - | o o o o o | ^ ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |



**Chief Concerns:** Are any of your injuries/complaints the result of an accident? Yes No

**If yes**, do you have a No-Fault claim associated with the accident? Yes No

**If no:** Please initial next to the following statement: My injury did not occur due to an accident and I therefore do not have a No-fault claim associated with this injury: _____

Did this injury occur while you were at work: Yes No

**If no:**Please initial next to the following statements: My injury did not occur at work or on the job: _____. I do not have a workers compensation claim associated with any of my injuries/complaints: _____

_____ _____

Patient Signature Date

---

**For Doctors Use only:**

**Additional Notes:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature_____ Date:_____