Confidential Introductory Patient Information Today's Date: _____

Name: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____

Address: _____ Business Phone: ( ) _____ Fax: ( ) _____

City: _____ State: _____ Zip: _____ Email Address: _____

Birth date: _____ Gender: _____ Number of Children: ___ Ages: _____

Occupation: _____ Contact in emergencies: _____ Phone: _____

Referred by: _____

Insurance Information

Insurance Provider: _____

Provider's Address and Phone: _____

Social Security Number: _____ Member ID: _____ Group ID: _____

Employer (Name and Address): _____

Insured's Name and Date of Birth (if other than patient): _____

Primary complaint: _____

How long have you had this condition? _____

Secondary complaint: _____

How long have you had this condition? _____

Please list any medications, herbs, or supplements you are currently taking, whether prescription or non-prescription: _____

_____

_____

_____

Serious Illnesses/Injuries/Surgeries/Hospitalizations	Dates	Outcome

✓	Allergies/Sensitivities (please specify)	Typical Reaction
	Pollen:	
	Medications:	
	Animal hair:	
	Dust, molds:	
	Food:	
	Other:	

Please check all that apply to you:

□ Frequent childhood illness
□ Frequent colds or sore throat
□ Allergies
□ Sinusitis
□ Lymph nodes enlarged
□ Lymph nodes removed
□ Shortness of breath
□ Asthma
□ Chronic cough
□ Nose bleeds
□ Itching
□ Hives
□ Eczema
□ Acne
□ Skin rashes
□ Dry skin
□ Headaches
□ Convulsions
□ HIV/AIDS
□ Hepatitis A/B/C
□ Venereal diseases

□ Diabetes
□ Hypoglycemia
□ Insomnia
□ Fatigue
□ Urinary difficulty
□ Urinary frequency
□ Sugar cravings
□ Food cravings
□ Excess appetite
□ Reduced appetite
□ Stomach pain
□ Excess weight gain
□ Excess weight loss
□ Intestinal gas
□ Bloating
□ Constipation
□ Diarrhea
□ Acid reflux
□ Hiatal hernia
□ Excess thirst
□ Excess sweating
□ Numbness
□ Muscle spasms
□ Aches/pains
□ Cold hands/feet

□ Cold body temperature
□ Hot body temperature
□ Hot flashes
□ Night sweats
□ Hair loss
□ Hair dry or brittle
□ Premature greying
□ Nails brittle
□ Forgetful
□ Difficulty concentrating
□ Mood swings
□ Sad/depressed
□ Anxiety
□ Irritability
□ Panic attacks
□ Rapid heartbeat or palpitations
□ Water retention
□ Bleeding gums
□ Dry mouth
□ Cold sores
□ Dental problems

□ Poor vision
□ Eye pain, redness, dryness, or itching
□ Seeing spots
□ Ear pain
□ Ringing in ears
□ Clogged/popping ears
□ Varicose veins
□ Hypertension
□ Hypotension
□ High Cholesterol
□ Mitral Valve Prolapse
□ Heart conditions, please specify: _____
□ Blood Pressure: _____/_____
□ Other: _____
_____
□ Latex allergy

Men:

Check all that apply:

□ Prostatitis □ Impotence
□ Other, please specify: _____

Women:

At what age did you start menstruating? _____ Age at menopause (if applicable) _____

Number of days between cycles: _____

Number of days of flow: _____ Color: _____

Check all that apply:

□ Heavy flow
□ Light flow
□ No flow
□ Spotting between periods
□ Discomfort or pain before period
□ Discomfort of pain during period

□ Hormone replacement
□ Osteoporosis
□ PMS symptoms, please specify: _____
_____
□ Birth control, please specify: _____

□ Menopausal symptoms, please specify: _____
_____
□ Other, please specify:
_____

Number of pregnancies: _____ Number of deliveries: _____

Family Medical History (Please list any significant family illnesses)

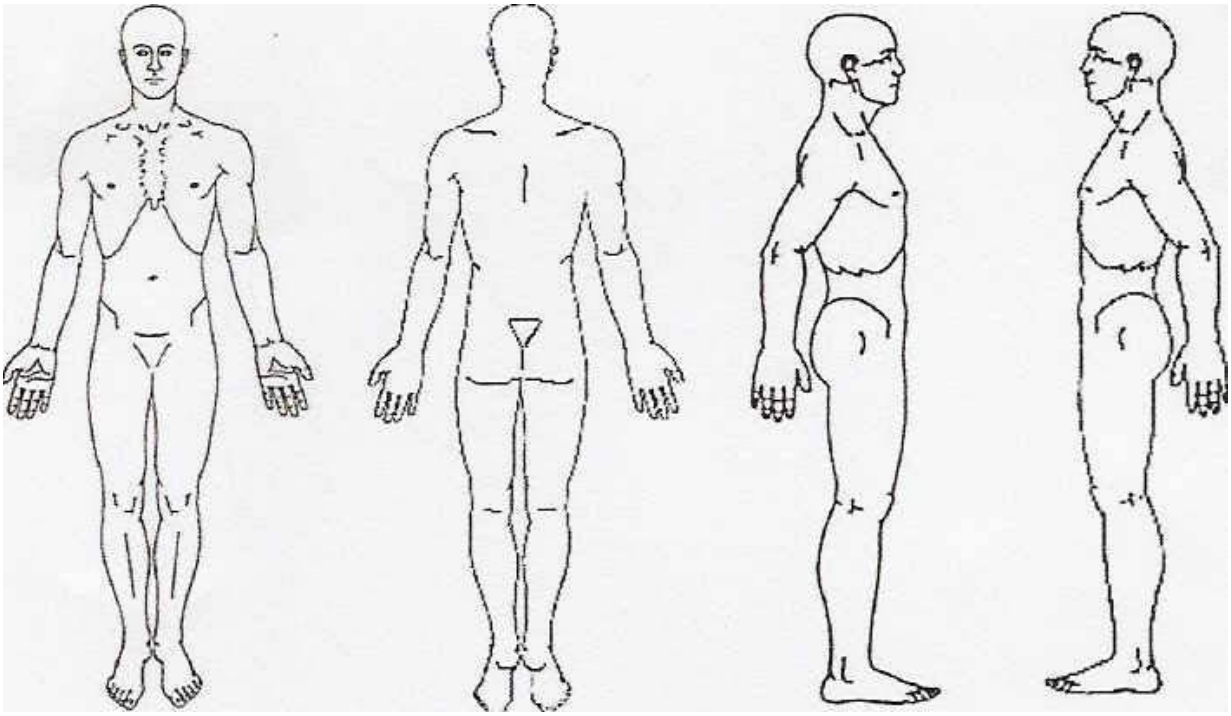
Mother _____

Father _____

Siblings _____

Grandparents _____

On the following drawing, please shade the areas that you would like addressed:



Please Note:
This office has a 24 hour cancellation policy. We ask that you notify us well in advance if you need to cancel or change your appointment. Payment in full will be due for all sessions cancelled with less than 24 hours. Monday appointments must be cancelled by Friday.

By signing here I agree to pay for any missed appointment when it is not cancelled with a minimum of 24 business hours notice.

_____ _____

Signed Printed Name

Date: _____