Date_____

Name_____

Address_____ Age_____ Birthdate_____

_____ Sex M F Ht_____ Weight_____

Primary Phone _____ cell home Relationship Single Married Divorced
Other Phone _____ cell home Significant Other Widowed

E Mail_____ Who Referred you? _____

Occupation_____
Workplace _____ Emergency Contact_____
Work Phone_____ Relationship_____Phone_____

Primary Care Provider_____ Practice _____
address_____

What is the major concern that brings you here?

What have you already done to address it?

Is it related to a(n) Auto Accident or Work Injury? (Circle one)
Date of Accident or Injury _____

Are you pregnant or trying to get pregnant? _____

Please list all operations and dates_____
_____
_____

Have you ever been advised to have any surgery or other treatment which was not done?
_____

Injuries (auto accidents, falls, etc.)_____
_____

Do you exercise? Yes No What type(s) and how frequently:_____
_____

Please list all medications you are taking and how frequently:
Prescription_____
_____

Non Prescription_____
_____

Dietary Supplements (vitamins, minerals, herbs, ect.)_____
_____
_____

Past long term medications_____

Indicate if you use any of the below and how frequently you use it:

Coffee/Tea/Cola_____
Tobacco_____
Alcohol_____
Sugar/Sweets_____
Salt_____

Please circle any that apply to you. List any relations that may have/had these.

Hemophilia/ Bleeding Disorders	_____
Arthritis	_____
Diabetes	_____
High or low blood Pressure	_____
Asthma /Allergies	_____
Epilepsy/ Seizures	_____
Mental Health Problems	_____
Cancer	_____
Heart disease	_____
Ulcers	_____
Stroke	_____
Kidney disease	_____
Scarlet Fever	_____
TB	_____
Mono	_____
Alcohol or drug problems	_____

Have you ever had any of the following (fill in date)

Sexually Transmitted Disease	_____
Herpes	_____
Hepatitis	_____

The type of diet you usually follow: _____

Average Daily Diet

Morning	Afternoon	Evening

I declare the above to be true and complete to the best of my knowledge.
I give you permission to contact me by email and send me occasional notices.
I give you permission to contact and share information with my primary care provider in regards to my care.

Signature _____
(parent or guardian if minor)
Date_____