

Who referred you to us? _____

Who is your primary health care provider/M.D. _____

Phone: _____

In an emergency notify: _____

Phone: _____ Relationship to you: _____

Main problem you would like us to help you with? _____

How long ago did this problem begin: _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Have they helped alleviate the condition/problem? _____

Are you currently receiving treatment for your problem? _____ If so please describe

Past Medical History

Significant Illnesses: _____

Surgeries: _____

Significant Trauma (i.e. Motor Vehicle Accidents, Falls, etc.) _____

Do you have or have you ever had, any infectious disease? (ex. Hep B, HIV) _____ If so please describe:

Medication: Include prescription, over the counter drugs, vitamins, herbs. etc. taken within the last three months: _____

Average or typical Blood Pressure _____ / _____ Average Pulse Rate: _____

Allergies: _____

Family Medical History (General Health)

Mother's Side: _____

Father's Side: _____

Siblings: _____

If any of the above are deceased, what was the cause? _____

Personal Birth History (prolonged labor, forceps, Caesarean, etc.) _____

Childhood Health: _____ Location of upbringing: _____

Current emotional health: _____ Current Quality of Life: _____

Current Relationship Quality: _____ Current predominant emotion: _____

Occupation: _____ Stress Level: _____

Have you had any unusual stresses recently? _____

Favorite time of year? _____ Worst? _____

Hobbies and recreational habits: _____

Do you have a regular exercise program: _____ Please describe: _____

Have you traveled abroad in the past year? _____ Where? _____