

Date ___/___/___

Name: Last _____ First _____ Middle _____ Birth date ___/___/___

Age ___ Gender _____ Phone _____ Email _____

Street _____ City _____ State _____ Zip _____

Insurance _____ Occupation _____ Employer _____

Spouse _____ Referred by _____, who is a _____

Emergency contact name _____ Phone _____ Relationship _____

Please check all that apply:

- Overweight
- Cancer
- Stroke
- Heart disease
- AIDS (HIV)
- Hepatitis B (HBV)
- Hepatitis C (HCV)

Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headache	<input type="checkbox"/> Neck / shoulder	<input type="checkbox"/> Back	<input type="checkbox"/> Hip / leg	<input type="checkbox"/> Knee
	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Tennis elbow	<input type="checkbox"/> Carpal tunnel	<input type="checkbox"/> Sprains	<input type="checkbox"/> Other pain
Neurological	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Bell's palsy	<input type="checkbox"/> TMJ	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Parkinson's disease
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Stress	<input type="checkbox"/> Panic disorder	<input type="checkbox"/> Alzheimer's disease
Cardiovascular	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Coronary artery disease	
Respiratory	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pharyngitis	<input type="checkbox"/> Emphysema
Digestive	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> IBS
	<input type="checkbox"/> Ulcer disease	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Gastroparesis	<input type="checkbox"/> Hiccups	<input type="checkbox"/> Crohn's	<input type="checkbox"/> Biliary colic
Endocrine / Skin	<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Shingles	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Acne	<input type="checkbox"/> Eczema
reproductive	<input type="checkbox"/> infertility	<input type="checkbox"/> Menopause	<input type="checkbox"/> Cramps / Premenstrual syndrome	<input type="checkbox"/> PCOS	<input type="checkbox"/> Endometriosis	

Additional conditions not listed above: _____

Surgical history: _____

Current medications: _____

Supplements/herbs: _____

Smoking: Current (how much?) _____ Past Never **Alcohol:** Y / N if yes, how much? _____

Rate (0-10): Energy: _____ Sleep: _____ Appetite: _____

Chief Complaints (by priority):

1 _____

2 _____

3 _____

4 _____

Please list foods that you eat on a regular basis

Breakfast: _____

Lunch: _____

Dinner: _____

Beverages/snacks: _____

Diagnostic testing and treatment for current condition(s): _____
