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

_____