Welcome to Our Clinic!

Please bring this completed paperwork and all medications and supplements you're currently taking to your first visit.
If you open this pdf file with Adobe Acrobat(download *here*), you will be able to fill it out on your computer before printing. Otherwise, please print it, and complete it by hand.

Name: _____ Date: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Primary Phone:_____ Secondary Phone: _____

Email Address: _____

Date of Birth:_____ Gender:_____

Marital Status:

☐ Married ☐ Widowed
☐ Separated ☐ Single
☐ Divorced ☐ Partnership

Live with:

☐ Spouse ☐ Parents ☐ Other:
☐ Partner ☐ Children _____
☐ Friends ☐ Alone

Occupation: _____ Hours per week:_____ Retired: Yes☐ No☐

Employer: _____

How did you hear about our clinic? _____

Can we thank the person who referred you? If yes, please list_____

Has any other family member been a patient at this clinic? _____

Emergency Contact: _____

Relationship:_____ Phone: _____

Address: _____

Are you currently being treated by another healthcare practitioner/s? Yes☐ No☐

If yes, please list:_____

Name of Primary Care Physician or Healthcare Office:_____

Phone Number: _____ Fax: _____

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HEALTH HISTORY

When and where did you last receive medical or health care? _____

What was the reason? _____

Height:_____ Weight:_____lbs. Weight 1yr ago:_____ Max Weight:_____ When: _____

When during the day is your energy the best?_____ worst? _____

Please rate your stress level: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
10=most stressed

What are your most important health problems? List in order of importance:

1) _____

2) _____

3) _____

4) _____

Do you have any known contagious diseases at this time? Yes☐ No☐

If yes, what? _____

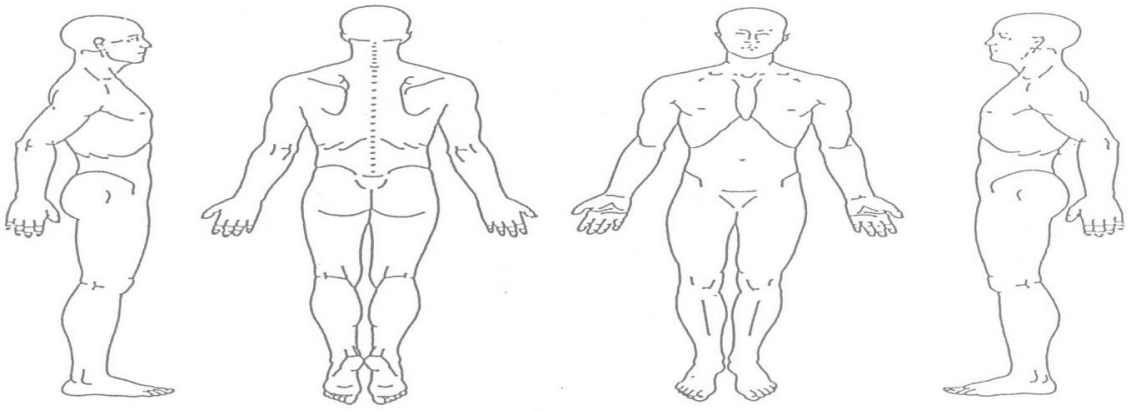
Have you had any vaccinations as an adult? Yes☐ No☐

If yes, which vaccinations and when?_____

What prescription and over the counter medications do you currently take or use?

☐ Laxatives	☐ Pain relievers	☐ Sleeping aids
☐ Muscle relaxants	☐ Thyroid medications	☐ Antacids
☐ Appetite suppressants	☐ Antibiotics	☐ Cortisone
☐ Blood Pressure Medications	☐ Antidepressants	☐ Antipsychotics

Please mark painful or distressed areas below:



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PAST HEALTH HISTORY

(include dates)

Major Illnesses: _____

Major Surgeries: _____

Other Significant Physical or Emotional Truama:_____

Check any of the following diseases you've had:

☐ Appendicitis	☐ Scarlet Fever	☐ Chicken Pox	☐ Rheumatic Fever
☐ Epilepsy	☐ Mumps	☐ Measles	☐ German Measles
☐ Whooping Cough	☐ Diphtheria	☐ Malaria	☐ Pleurisy
☐ Bronchitis	☐ Tuberculosis	☐ Pneumonia	☐ Influenza
☐ Goiter	☐ Eczema	☐ Low Back Pain	☐ Anemia
☐ Heart Disease	☐ High Cholesterol	☐ Arthritis	☐ Diabetes
☐ Sexually Transmitted: _____		☐ Addictions: _____	
☐ Cancer: _____		☐ Other: _____	

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-rays, CAT Scans, MRIs, EEG, EKGs have you had?

_____Year:_____ _____Year: _____

_____Year:_____ _____Year: _____

FAMILY MEDICAL HISTORY

☐ Diabetes	☐ Heart Disease	☐ Asthma	☐ Arthritis
☐ Cancer	☐ High Cholesterol	☐ Stroke	☐ Anemia
☐ Glaucoma	☐ High Blood Pressure	☐ Kidney Disease	☐ Tuberculosis
☐ Epilepsy	☐ Mental Illness	☐ Hives	☐ Allergies

Other relevant family history? _____

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HABITS

Breakfast: _____ Lunch: _____

Dinner: _____

Snacks: _____ Drinks: _____

What food or beverage do you consume the most of or absolutely cannot live without?

_____

What is your daily water intake? _____ oz. Source? _____
(tap, filtered, reverse osmosis, distilled)

Main interests and hobbies? _____

_____

Do you exercise? Y ☐ N ☐ How often? _____

If yes, what kind? _____

Do you have a religious or spiritual practice? Y ☐ N ☐

If yes, what kind? _____

Average 6-8 hours sleep?	Y ☐ N ☐	Do you drink sodas?	Y ☐ N ☐ P ☐
Sleep well?	Y ☐ N ☐	Do you eat refined sugar?	Y ☐ N ☐ P ☐
Awaken rested?	Y ☐ N ☐	Do you eat 3 meals a day?	Y ☐ N ☐
Have a supportive relationship?	Y ☐ N ☐	Do you go on diets often?	Y ☐ N ☐
Have a history of abuse?	Y ☐ N ☐	Do you eat out often?	Y ☐ N ☐
Any major traumas?	Y ☐ N ☐	Do you add salt to foods?	Y ☐ N ☐ P ☐
Use recreational drugs?	Y ☐ N ☐ P ☐		
Been treated for drug dependence?	Y ☐ N ☐	Watch television?	Y ☐ N ☐
Use alcoholic beverages?	Y ☐ N ☐ P ☐	How many hours? _____	
Treated for alcoholism?	Y ☐ N ☐ P ☐	Read?	Y ☐ N ☐
Do you use tobacco?	Y ☐ N ☐ P ☐	How many hours? _____	
How many years? _____			
Packs per day? _____		Enjoy your work?	Y ☐ N ☐
Do you drink coffee?	Y ☐ N ☐ P ☐	Spend time outside?	Y ☐ N ☐
Do you drink black/green tea?	Y ☐ N ☐ P ☐	Take vacations?	Y ☐ N ☐

REVIEW OF SYSTEMS

Y = Yes (current condition) **N = No (non-issue)** **P = Past Problem (serious)**

Mental/Emotional

Treated for Emotional Problems	Y☐ N☐ P☐
Mood Swings	Y☐ N☐ P☐
Considered/Attempted Suicide	Y☐ N☐ P☐
Poor Concentration	Y☐ N☐ P☐
Depression	Y☐ N☐ P☐
Anxiety or Nervousness	Y☐ N☐ P☐
Tension	Y☐ N☐ P☐
Memory Problems	Y☐ N☐ P☐

Neurological

Seizures	Y☐ N☐ P☐
Muscle Weakness	Y☐ N☐ P☐
Vertigo or Dizziness	Y☐ N☐ P☐
Loss of Memory	Y☐ N☐ P☐
Paralysis	Y☐ N☐ P☐
Numbness or Tingling	Y☐ N☐ P☐
Easily Stressed	Y☐ N☐ P☐
Loss of Balance	Y☐ N☐ P☐

Immune

Reactions to Immunizations	Y☐ N☐ P☐
Chronic Fatigue Syndrome	Y☐ N☐ P☐
Chronically Swollen Glands	Y☐ N☐ P☐
Reactions to Vaccinations	Y☐ N☐ P☐
Chronic Infections	Y☐ N☐ P☐
Slow Wound Healing	Y☐ N☐ P☐

Endocrine

Hypothyroid	Y☐ N☐ P☐
Hypoglycemia	Y☐ N☐ P☐
Excessive Thirst	Y☐ N☐ P☐
Fatigue	Y☐ N☐ P☐
Heat or Cold Intolerant	Y☐ N☐ P☐
Diabetes	Y☐ N☐ P☐
Excessive Hunger	Y☐ N☐ P☐
Seasonal Depression	Y☐ N☐ P☐

Skin

Rashes	Y☐ N☐ P☐
Acne, Boils	Y☐ N☐ P☐
Lumps	Y☐ N☐ P☐
Color Change	Y☐ N☐ P☐
Eczema, Hives	Y☐ N☐ P☐
Itching	Y☐ N☐ P☐
Perpetual Hair Loss	Y☐ N☐ P☐
Night Sweats	Y☐ N☐ P☐

Head

Headaches	Y☐ N☐ P☐
Migraines	Y☐ N☐ P☐
Head Injury	Y☐ N☐ P☐
Jaw/TMJ Problems	Y☐ N☐ P☐

Mouth and Throat

Frequent Sore Throat	Y☐ N☐ P☐
Teeth Grinding	Y☐ N☐ P☐
Gum Problems	Y☐ N☐ P☐
Dental Cavities	Y☐ N☐ P☐
Copious Saliva	Y☐ N☐ P☐
Sore Tongue/Lips	Y☐ N☐ P☐
Hoarseness	Y☐ N☐ P☐
Jaw Clicks	Y☐ N☐ P☐

Neck

Lumps	Y☐ N☐ P☐
Goiter	Y☐ N☐ P☐
Swollen Glands	Y☐ N☐ P☐
Pain or Stiffness	Y☐ N☐ P☐

Nose and Sinuses

Frequent Colds	Y☐ N☐ P☐
Stuffiness	Y☐ N☐ P☐
Sinus Problems	Y☐ N☐ P☐
Nose Bleeds	Y☐ N☐ P☐
Hayfever	Y☐ N☐ P☐
Loss of Smell	Y☐ N☐ P☐

Eyes

Spots in Eyes Y☐ N☐ P☐
Impaired Vision Y☐ N☐ P☐
Blurriness Y☐ N☐ P☐
Color Blindness Y☐ N☐ P☐
Double Vision Y☐ N☐ P☐
Cataracts Y☐ N☐ P☐
Eye Pain/Strain Y☐ N☐ P☐
Tearing or Dryness Y☐ N☐ P☐
Glaucoma Y☐ N☐ P☐
Glasses or Contacts? Y☐ N☐ P☐

Ears

Impaired Hearing Y☐ N☐ P☐
Earaches Y☐ N☐ P☐
Ringing Y☐ N☐ P☐
Dizziness Y☐ N☐ P☐

Musculoskeletal

Joint Pain or Stiffness Y☐ N☐ P☐
Broken Bones Y☐ N☐ P☐
Muscle Spasms or Cramps Y☐ N☐ P☐
Arthritis Y☐ N☐ P☐
Weakness Y☐ N☐ P☐
Sciatica Y☐ N☐ P☐

Respiratory

Cough Y☐ N☐ P☐
Spitting-up Blood Y☐ N☐ P☐
Sputum Y☐ N☐ P☐
Emphysema Y☐ N☐ P☐
Asthma Y☐ N☐ P☐
Wheezing Y☐ N☐ P☐
Shortness of Breath Y☐ N☐ P☐
Pain on Breathing Y☐ N☐ P☐

Cardiovascular

High/Low Blood Pressure Y☐ N☐ P☐
Blood Clots Y☐ N☐ P☐
Phlebitis Y☐ N☐ P☐
Swelling in Ankles Y☐ N☐ P☐
Angina Y☐ N☐ P☐
Murmurs Y☐ N☐ P☐
Fainting Y☐ N☐ P☐
Palpitations/Fluttering Y☐ N☐ P☐
Chest Pain Y☐ N☐ P☐

Blood/Peripheral Vascular

Easy Bleeding or Bruising Y☐ N☐ P☐
Deep Leg Pain Y☐ N☐ P☐
Varicose Veins Y☐ N☐ P☐
Anemia Y☐ N☐ P☐
Cold Hands/Feet Y☐ N☐ P☐
Thrombophlebitis Y☐ N☐ P☐

Gastrointestinal

Trouble Swallowing Y☐ N☐ P☐
Change in Thirst Y☐ N☐ P☐
Change in Appetite Y☐ N☐ P☐
Nausea/Vomiting Y☐ N☐ P☐
Ulcer Y☐ N☐ P☐
Jaundice (yellow skin) Y☐ N☐ P☐
Gall Bladder Disease Y☐ N☐ P☐
Liver Disease Y☐ N☐ P☐
Hemorrhoids Y☐ N☐ P☐
Heartburn Y☐ N☐ P☐
Abdominal Pain or Cramps Y☐ N☐ P☐
Belching or Passing Gas Y☐ N☐ P☐
Constipation Y☐ N☐ P☐
Diarrhea Y☐ N☐ P☐
Black Stools Y☐ N☐ P☐
Blood in Stool Y☐ N☐ P☐
Bowel Movements: How often? _____
Is this a change? Y☐ N☐

Urinary

Frequent Infections Y☐ N☐ P☐
Pain on Urination Y☐ N☐ P☐
Frequency at Night Y☐ N☐ P☐
Increased Frequency Y☐ N☐ P☐
Inability to Hold Urine Y☐ N☐ P☐
Kidney Stones Y☐ N☐ P☐

FOR MEN

Date of last prostate check-up: _____ PSA results: _____

Manual prostate exam results: _____

Please indicate if you have experienced the following in the past 3 months:

☐ Prostate Problems ☐ Erectile Dysfunction ☐ Incontinence ☐ Dribbling

☐ Retention of Urine ☐ Increased Libido ☐ Impotence ☐ Hernias

☐ Premature Ejaculation ☐ Decreased Libido ☐ Testicular Pain ☐ Groin Pain

☐ Pain on Urinating ☐ Difficulty Starting Urination

FOR WOMEN

Age of first period: _____ Length of cycle (days): _____ Date of last period: _____

Are you pregnant? Y☐N☐ Maybe☐ Age of last period (menopause): _____

Number of pregnancies: Date of last gynecologic exam: _____

Number of live births: _____ Pap smear: Negative / Positive

Number of miscarriages: _____ Mammogram results: _____

Number of abortions: _____ Bone Density Scan results: _____

Have you been diagnosed with:

☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis

☐ Ovarian Cysts ☐ Polycystic Ovarian Syndrome ☐ Pelvic Inflammatory Disease

☐ Other: _____

Are you on hormones? Y☐ N☐ If so, what? _____

Are you currently on birth control? Y☐ N☐ If yes, for how long? _____

Are you having difficulty getting pregnant? Y☐N☐ If so, for how long? _____

Please indicate if you have experienced the following in the past 3 months:

☐ Vaginal Discharge ☐ Vaginal Dryness ☐ Hot Flashes ☐ Night Sweats

☐ Increased Libido ☐ Swollen breasts ☐ Mood Swing ☐ Cramping

☐ Decreased Libido ☐ Pain During Menses ☐ Pain After Menses

☐ Pain Before Menses ☐ Pain on Urination ☐ Irregular Menses

☐ Bleeding Between Cycles ☐ No Menses ☐ Bloating

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Your time, thoughtfulness, and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this clinic? _____

2) What do you know about our approach? _____

_____

3) What three expectations do you have from this visit to our clinic?

   i. _____

   ii. _____

   iii. _____

4) What long-term expectations do you have from working with our clinic? _____

_____

5) What expectations do you have of me personally as your healthcare practitioner? _____

_____

6) Please rate on scale how serious you are about getting well. What is your present level of commitment to addressing any lifestyle habits and choices that are causing or contributing to your symptoms? (10 being 100% committed)

0% 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 100%

8) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? _____

Self-destructive lifestyle habits? _____

9) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you? _____

10) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____

11) Are you willing to follow a treatment program designed to help you return to health for at least three months? Yes ☐ No ☐

12) Are you willing to take supplements? Yes ☐ No ☐

13) Are you willing to make dietary changes? Yes ☐ No ☐

14) Are you willing to start a moderate exercise program? Yes ☐ No ☐

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OFFICE POLICIES

- **Cancellation Policy**: Missed appointments without 24 hours prior notice must pay the full cost of the visit. Please give prior notice of at least 24 hours so other patients can be helped in that time slot.
- **Payment Policy**: We charge for services provided. Payment is due at the time of service. Cash, check, credit, and debit cards are accepted. There will be a $30.00 fee for all returned checks.
- **Please refrain** from wearing any perfume, cologne, aftershave, hairspray, essential oils, makeup, etc. to respect others in the clinic that may be chemically sensitive.
- **Please wear** comfortable pants or shorts to your visit and avoid wearing skirts.
- **Please notify us** when your address and/or phone number changes as soon as possible.
- **Cell Phones**: Please turn off all cell phones or put them in airplane mode before entering the treatment rooms.

OUR POLICY ON INSURANCE

You will be provided with a superbill with the appropriate information and codes for you to send to your medical insurance company. It is your responsibility to be aware of the medical services covered by your insurance policy. You will pay our clinic at the time of service and get reimbursed directly from your insurance company.
If you're seeking care following a motor vehicle accident and are using MVA insurance, we will bill your insurance directly.

Patient Signature:_____ Date: _____

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent.

As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:

- ✓ For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- ✓ With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- ✓ To protect the public's health, such as reporting when the flu is in your area.
- ✓ To make required reports to the police, such as gunshot wounds.
- ✓ Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed.

Please check all that apply:

☐ Please do not phone me at home. Use this alternate phone number: _____

☐ Please do not phone me at work. Use this alternate phone number: _____

☐ Please do not leave messages on my answering machine.

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address: _____

_____

Other request (please describe): _____

_____

X _____

Patient/Guardian Signature **Date**

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor)