

Patient Name: _____

Who referred you to us? _____

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

Address: _____ Phone: _____

In case of emergency notify: _____

Phone: _____ Relationship to you: _____

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

When 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? _____

Does anything make the problem better or worse? _____

If you are currently receiving treatment, please describe: _____

Past Medical History: (please give approximate dates where appropriate)

Illnesses: _____

Surgeries: _____

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

Do you have, or have you ever had, any infectious disease? _____ If so, please describe: _____

Medications: Include prescription, over the counter drugs, vitamins, and herbs taken within the last three months: _____

Allergies: _____

Do you drink alcohol? _____ Amount and frequency: _____

Do you smoke cigarettes? _____ Did you ever smoke? _____ Amount and frequency: _____

Do you drink coffee: _____ Amount and frequency: _____

Do you have a regular exercise program? _____ Describe: _____

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

Family Medical History (General Health):

Mother's Side: _____

Father's Side: _____

Siblings: _____

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

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

Childhood health: _____ Location of upbringing: _____

Current emotional health: _____ Current predominant emotion: _____

Current Relationship quality: _____ Current Quality of Life: _____

Any unusual stresses recently? _____ Current Stress level: _____

Favorite time of year: _____ Worst time of year: _____

Please list destinations of travel abroad in the past year: _____