



## 1. Basic Patient Information

Name \_\_\_\_\_ (*first*) \_\_\_\_\_ (*middle*) \_\_\_\_\_ (*last*)

Address \_\_\_\_\_ (*street*)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Telephone \_\_\_\_\_ - \_\_\_\_\_ (*home*) \_\_\_\_\_ - \_\_\_\_\_ (*work*) \_\_\_\_\_ - \_\_\_\_\_ (*cell*)

Email \_\_\_\_\_ @ \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (*mm/dd/yyyy*) \_\_\_\_\_ Male \_\_\_\_\_ Female

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ *or* Drivers License Number \_\_\_\_\_

Marital Status \_\_\_\_\_ Married/Partnership \_\_\_\_\_ Separated/Divorced \_\_\_\_\_ Single

Education \_\_\_\_\_

Profession \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ (*street*)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact \_\_\_\_\_ (*name*)

Telephone \_\_\_\_\_ - \_\_\_\_\_ (*home*) \_\_\_\_\_ - \_\_\_\_\_ (*work*) \_\_\_\_\_ - \_\_\_\_\_ (*cell*)

Address \_\_\_\_\_ (*street*)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Relationship \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ (*name*)

Address \_\_\_\_\_ (*clinic name*) \_\_\_\_\_ (*street*)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Did your physician express to be kept informed on treatment progress? \_\_\_\_ YES \_\_\_\_ NO  
(*if yes, please duly fill out records release form*)



## 2. Referral Information

How did you hear about our clinic? \_\_\_\_\_ (*media, internet, etc*)

Have you been referred to our clinic? \_\_\_\_\_ YES \_\_\_\_\_ NO

May we thank the person who referred you? \_\_\_\_\_ YES \_\_\_\_\_ NO

Name \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_

## 3. ANAMNESIS

### 3.1. Chief Medical Complaint

What are the chief health concerns you wish to address?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

### 3.2. Current and Past Treatment

Have you received treatment for these problems? \_\_\_\_\_ YES \_\_\_\_\_ NO, if yes, which:

\_\_\_\_\_ Conventional \_\_\_\_\_ Naturopathic \_\_\_\_\_ Osteopathic \_\_\_\_\_ Chiropractic \_\_\_\_\_ Oriental

Please list the names of the physicians you have formerly consulted with for this problem:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



### 3.3. Medications and Supplements

What medications are you currently taking?

1. Prescription: \_\_\_\_\_
2. OTC: \_\_\_\_\_
3. Dietary Supplements: \_\_\_\_\_
4. Raw or Dried Herbs: \_\_\_\_\_

### 3.4. Allergies

Are you allergic to any medications? \_\_\_ YES \_\_\_ NO, if yes, which:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Are you allergic to any food products? \_\_\_ YES \_\_\_ NO, if yes, which:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Are you allergic to any environmental products? \_\_\_ YES \_\_\_ NO, if yes, which:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### 3.5. Family History

Do you currently have any known contagious diseases? \_\_\_ YES \_\_\_ NO, if yes, which:

1. \_\_\_\_\_
2. \_\_\_\_\_

Have you ever been diagnosed with a mental disorder? \_\_\_ YES \_\_\_ NO, if yes, which:

1. \_\_\_\_\_
2. \_\_\_\_\_