

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. 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. Hospitalizations and Surgeries

Have you had any surgeries in the past? ___ YES ___ NO, if yes, which:

1. _____
2. _____
3. _____

3.6. Family History (Please check if applicable)

Illness	Father	Mother	Brother	Sister
Cancer				
Diabetes				
Heart Disease				
Stroke				
Mental Illness				

3.7. Communicable Diseases

Do you have an active contagious illness? ___ YES ___ NO, if yes, which:

Pulmonary Tuberculosis		HIV / AIDS	
Measles		Malaria	
Hepatitis A, B, C		Other	