Today's Date	Patient's name (first, m.i., last)				
Spouse's name		Patient's Address			
City	State	Zip	Home phone ( )	Cell phone ( )	
Birthdate	Age	Sex	E-mail:		
Marital status M S D W	Occupation		Employer		
Employer's Address			City	State	Zip
Who may we thank for referring you to our office?					

PLEASE CHECK OFF ANY OF THE FOLLOWING SYMPTOMS THAT YOU EXPERIENCE:

DIGESTIVE:

- ❑ Acid Reflux
- ❑ Irritable Bowel Syndrome
- ❑ Indigestion
- ❑ Heartburn
- ❑ Abdominal Pain
- ❑ Stomach Ache
- ❑ Gas
- ❑ Bloating
- ❑ Diarrhea
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Leaky Gut Syndrome

DERMATOLOGICAL:

- ❑ Eczema
- ❑ Skin Rash
- ❑ Hives
- ❑ Dermatitis

RESPIRATORY:

- ❑ Sinusitis / Congestion
- ❑ Hay Fever
- ❑ Wheezing
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Itchy, Watery Eyes
- ❑ Sneezing
- ❑ Runny Nose
- ❑ Postnasal Drip
- ❑ Sinus Pain / Pressure
- ❑ Sinus Headache

MOODS:

- ❑ Depression
- ❑ Anxiety
- ❑ Mood Swings
- ❑ ADD / ADHD
- ❑ Difficulty Concentrating

PAIN / STRUCTURAL:

- ❑ Back Pain
- ❑ Neck Pain
- ❑ Disc Problems
- ❑ Stenosis
- ❑ Sciatia
- ❑ Headaches / Migraines
- ❑ Shoulder Pain
- ❑ Elbow Pain
- ❑ Wrist / Hand pain
- ❑ Carpal Tunnel Syndrome
- ❑ Hip Pain
- ❑ Knee Pain
- ❑ Ankle / Foot Pain
- ❑ Plantar Fascitis
- ❑ Failed Back Surgery
- ❑ Other_______________
- ❑ Other_______________

CONDITIONS:

- ❑ Fibromyalgia
- ❑ Chronic Fatigue
- ❑ Insomnia
- ❑ High Blood Pressure
- ❑ Arthritis
- ❑ Parkinson's Disease
- ❑ Lupus
- ❑ Restless Leg Syndrome
- ❑ Multiple Sclerosis
- ❑ RSD
- ❑ Trigeminal Neuralagia
- ❑ Neuropathy
- ❑ Dizziness / Meniere's
- ❑ Tinitis
- ❑ Numbness / Tingling
- ❑ Other_______________

Which of the above concerns you the most? ____

____

How long have you been bothered by this condition?____

____

What is your current pain / symptom level on a scale of 1-10 ? (10 being severe, 1 being mild)________________________

What have you tried to correct the problem?____

____

PLEASE CHECK THE BOXES OF HOW THIS AFFECTS YOUR LIFE

- ❑ Moody
- ❑ Irritable
- ❑ Interrupt Sleep
- ❑ Restricted on Daily Activities
- ❑ Slower in Movement
- ❑ Difficult Decision Making
- ❑ Poor Attitude
- ❑ Unable to work long hours
- ❑ Lose Patience with Spouse or Children
- ❑ Restricted Household Duties
- ❑ Decreased Productivity
- ❑ Exhausted at the end of the day
- ❑ Interferes with ability to participate in hobbies or other desired activities
- ❑ Hinders ability to exercise or participate in sports
- ❑ Other_______________
- ❑ Other_______________

On a scale of 1-10, How commited are you to getting better? 1 2 3 4 5 6 7 8 9 10

Please list any known allergies: ____

____

____

Medications you are currently taking: ____

____

Supplements you are currently taking: ____

____

____

Please indicate if you are on a Specialized Diet: ____

____

Do you have any questions or concerns that you would like to address with the doctor? ____________________

____

____

Do you smoke? Yes No If yes, how much per day? ____

Do you drink alcohol? Yes No If yes, how much per day / week? ____

Do you a have a pacemaker? Yes No

Have you had any surgeries? Yes No If yes, Please List what procedure and when: ____________________

____

____

(Females) Are you pregnant? Yes No

Please list any doctors you have seen for this problem:

____

____

____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM SO WE MAY SERVE YOU BETTER.

Signature ____ Date ____________________

(if under the age of 18, must be signed by parent or legal guardian.)