Patient Information Form

IMPORTANT: This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel certain questions do not pertain to your present condition(s). Thank you.

Today's date: ___________ Name: ____ Gender: ___ M ___ F
Home address: ____ City: _______________________
State: ____ Zip code: _______ Email address: ____
Date of birth: ______________ Age: _____
Cell phone number: _________________________ Alternate phone number: ________________________
Emergency contact Name: _______________________________ Relationship: _______________________
Contact phone number: _________________________________
Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ With a significant other
Are you a caregiver for dependents? Yes ___ No ___ If yes, how many children? ____ How many adults ___
Occupation: ____ Number of years in this type of work? ____

PHYSICIANS/PROVIDERS
Primary Care Physician (PCP): ____
Please provide the name and title of all other practitioner(s), the condition(s) being treated and the length of time you have been receiving this treatment.

Practitioner Name: Condition(s) Date of Treatment Phone Number
____
____
____

Insurance information for Lab order purposes:
Primary Insurance Company: __________________________ Name of Policy holder: ____________________
Mailing address: ____ City: _________ State: ___ Zip: _______
Relationship to Insured: __________________________________ Policy Holder's DOB: __________________
Policy#: ____ Group Name/Number: __________________

REASON FOR TODAY'S VISIT: ____
CURRENT HEALTH CONCERNS – Please list your top 3 health concerns in order of priority.

1. ____
2. ____
3. ____

HOSPITALIZATION'S, SURGERIES, PROCEDURES, TRANSPLANTS AND/OR INJURIES (please include the dates)
____
____
____

MEDICATIONS
Please list any medications you are currently taking, along with doses and the reason(s) you are taking them.

Medications	Reason	Date Began	Dose	Helps: Y or N

SUPPLEMENTS
***Please list any supplements (including vitamins, herbs and minerals) along with doses and the reason why you are taking them.**

Supplements, vitamins, etc.	Reason	Date Began	Dose	Helps: Y or N

ALLERGIES
Please list all allergies and reactions.

____
____
____

FAMILY HISTORY
Please describe your family's health, including current age or age at death and major illness history (diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)

Member	**Living?/Age**	**Major illness(s) or Chronic Condition(s)**
Mother		
Father		
Sister/Brother		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

PLEASE CHECK THE FOLLOWING MEDICAL CONDITIONS THAT APPLY TO YOU:

__ Alcoholism or substance abuse
__ Arthritis/Joint Disease
__ Blood clot/Phlebitis
__ Cancer (Specific type)_______
__ Diabetes
__ Digestive (Ulcerative Colitis, Crohn's disease, etc.)
__ Frequent infections
__ Allergies/Sensitivities (Medicines, Skin, Food)
__ Heart Attack, Heart Disease
__ Heart failure
__ High blood pressure
__ High Cholesterol
__ Liver disease, Hepatitis
__ Lung disease (Asthma, COPD)
__ Mental trouble/depression/ Anxiety, etc.
__ Thyroid Disease
__ Urinary difficulties (incontinence, infections, etc.)
__ Other __________________

<u>WOMEN'S HEALTH</u>

Age of first menses ____
Duration of menses ____
Unusual character _____
Perimenopausal _______
Breast lumps __________
Number of Pregnancies ____
Number of Births _________
Number of Miscarriages ____
Number of Abortions ______
Difficult Births ____________
Birth Control ____________
What type? _____________
Vaginal discharge or sores __
Fertility problems _________

First date of last menstrual cycle ________________ Date of last Pap Smear ____/____/________

Did you have any abnormal findings in your last test or anytime in the past? If yes, please provide details:

____

<u>MEN'S HEALTH</u>

Date of last prostate exam ___/___/______ PSA test __________ Colonoscopy _____________

Do you have; Prostate problems _________ Testicular cancer __________
Vasectomy _____________ Sexual dysfunction/Impotence ____

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THESE SYMPTOMS (IN THE LAST YEAR)

<u>GENERAL</u>
__ Fever
__ Tremors
__ Changes in appetite
__ Chills
__ Fatigue
__ Night sweats
__ Poor sleep/insomnia
__ Day sweating
__ Headaches
__Bleeding or bruising
__ Emotional changes

<u>CARDIOVASCULAR</u>
__ Dizziness
__ Swelling of hand
__ Irregular heart beat
__ Fainting
__ Difficulty in breathing
__ Palpitations
__ Low blood pressure
__ Cold sweats
__ Chest pain
__ Swelling of feet
__ Phlebitis
__ Other: _______

<u>RESPIRATORY</u>
__ Cough
__ Pain w/deep breath
__ Difficulty breathing
__ Bronchitis
__ Shortness of breath
__ Easily winded w/ exertion or when laying down
__ Coughing up blood
__ Production of phlegm

<u>GASTROINTESTINAL</u>
__ Nausea
__ Abdominal pain/ cramps
__ Vomiting
__ Constipation
__ Indigestion / reflux
__ Diarrhea
__ Blood in stools
__ Hernia
__ Hemorrhoids

<u>GENITOURINARY</u>
__ Pain in urination
__ Decrease in urine
__ Kidney stones
__ Urgent urination
__ Blood in urine
__ Waking up to urinate How often?________
__ Frequent urination
__ Unable to hold urine

<u>NEUROPHYSICOLOGICAL</u>
__ Areas of numbness
__ Anxiety
__ Lack of coordination
__ Poor memory
__ Dizziness
__ Loss of balance
__ Easily angered
__ Headaches
__ Fainting
__ Depression
__ Migraines
__ Mania
__ Susceptible to stress

<u>MUSCLUOSKELETAL</u>
__ Muscular weakness
__ Recent sprains
__ Muscle cramps
__ Spasms
__ Joint pain
__ Injuries or falls
__ Localized weakness
__ General aches
__ Joint instability

HABITS AND LIFESTYLES

Emotional Stress Scale (*Please Circle)*

__ 1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10

Do you smoke? ____ If yes, what? _________________ How many per day? ________ Since when? _________
How many attempts have you made to quit smoking? ___________________________
Do you drink alcohol? ____ If yes, what? _______________ How much? ____________ Since when? _________

EXERCISE
Do you exercise regularly? __________ If yes, describe what you do: ___________________________________

NUTRITION
What are your greatest nutrition concerns? ____
How many meals do you generally eat per day? _________________ Do you skip meals? __________________
Are you currently on a special diet? _______________What foods do you avoid? _________________________
Do you drink coffee? __________ If yes, how many cups per day? _____________
Do you have regular eating habits? __ Y __ N Do you have a healthy appetite? __ Y __ N
Do you eat more when feeling depressed or under stress? __ Y __ N
Do you experience sudden drops in energy? __ Y __ N If yes, when? ___________________________________
What was your weight one year ago? _____________
What is the most you have ever weighed? _________ When? _______________________________
How often do you have a bowel movement? ____

SLEEP AND RELAXATION

How many hours do you usually sleep per night? ___________ What time to you usually go to bed? ________
Do you wake up feeling refreshed? ____

I AUTHORZIE THE RELEASE OF MEDICAL INFORMATION TO:

____________________________________ ___________ ________________ _________________________
Name Relationship Phone Number Email address

____________________________________ ___________ ________________ _________________________
Name Relationship Phone Number Email address

Everything that I have answered and written in this form is true to the best of my knowledge. I will update this office when there are significant changes.

PATIENT NAME PRINTED: ___________________________________

PATIENT SIGNATURE: ______________________________________ DATE: __________________________