



Patient name: _____ Birth date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____ Check box for e-newsletter

Primary care physician: _____ Insurance company: _____

Emergency contact: _____ Phone: _____ Referred by: _____

PRESENT MEDICAL COMPLAINTS

PAST MEDICAL HISTORY

MEDICATIONS

SUPPLEMENTS

ALLERGIES	
Medications	Food

FAMILY HISTORY- Circle G(Grandparent) P(Parent) or S(Sibling)			
Cancer	G P S	Diabetes	G P S
CVD	G P S	Allergy/asthma	G P S
Hypertension	G P S	Osteoporosis	G P S
Stroke	G P S	Autoimmune	G P S

SOCIAL HISTORY- Circle Y(yes) N(no) or P(past)			
Alcohol	Y N P	Steroids	Y N P
Smoking	Y N P	Pain meds	Y N P
Recreation drg	Y N P	Antacids	Y N P
Addiction tx	Y N P	Laxatives	Y N P

EMOTIONAL- Circle Y(yes) N(no) or P(past)			
Anxiety	Y N P	Anger/irritable	Y N P
Depression	Y N P	High strung	Y N P
Insomnia	Y N P	Fear/panic	Y N P
Suicidal	Y N P	General mood	_____

EXERCISE		
Type	Frequency	Duration

SLEEP- Circle Y(yes) N(no)	
Do you have difficulty falling asleep?	Y N
Do you have difficulty staying asleep?	Y N
How many hours of sleep do you get?	_____
How many hours of sleep do you need?	_____

STRESS MANAGEMENT		
Type	Frequency	Duration
Meditation		
Massage		
Leisure activity		

DIET	
Water(oz)_____	Breakfast:
Coffee(oz)_____	Lunch:
Soda(oz)_____	Dinner:
Other(oz)_____	Snack:

REVIEW OF SYSTEMS- Circle all that currently apply							
Digestive		Emotions		Joint & Muscles		Mouth & Throat	
Diarrhea	Frequent Belching	Mood swings	Depression	Joint pain	Limited movement	Chronic coughing	Sore Throat
Constipation	Passing gas	Anxiety, fear	Aggressiveness	Swollen joints	Muscle Aches	Gagging	Swollen tongue
Bloated feeling	Stomach pains	Irritability, anger	Nervousness	Stiffness	Weakness	Often clear throat	Canker sores
Ears/Eyes		Female-Menses		Mind		Nose	
Itchy ears/drainage	Dark circles	Spotting	Dysmenorrhea	Headaches	Hyperactivity	Stuffy nose	Sneezing attacks
Ear aches/infection	Itchy/watery eyes	Irregularity	Discharge	Restlessness	Poor memory	Sinus problems	Mucous
Hearing loss	Blurred vision	Hot Flashes	PMS	Apathy	Poor concentration	Hay fever	Frequent illness
Energy		Skin		Weight		Heart/Lungs	
Fatigue	Insomnia	Acne	Flushing	Binge eating	Compulsive eater	Chest congestion	Palpitations
Dizziness	Faintness	Hives, rashes	Eczema	Cravings	Water retention	Asthma	Edema
Sluggishness	Lethargy	Hair loss	Excessive sweat	Weight gain	Underweight	Difficult breathing	Hypertension