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CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

Personal Information

First Name _____ Last Name _____ MI _____

What do you prefer to be called? _____

Address _____ City_____State_____Zip_____

Primary Phone _____ Secondary Phone_____

Birth Date _____/_____/_____ Sex ☐ M ☐ F Email Address _____

Whom may we thank for referring you? _____

Please list all healthcare practitioners whose care you have received within the last 12 months _____

_____

Emergency Contact Name _____ Relation _____

Emergency Contact's Phone Numbers _____

Main Complaint Information

What health concern(s) would you like help with? _____

_____

_____

_____

When did you first notice symptoms? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatments/therapies have you tried? _____

_____

Have they helped alleviate the condition/problem? _____

_____

Are you currently receiving other treatment for this problem? _____ If so, please describe _____

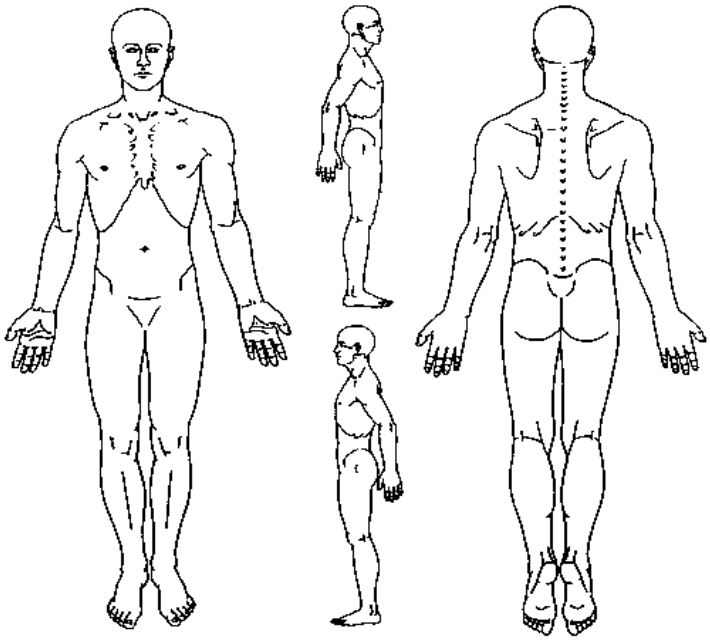
_____

Do you have any other problems you would like us to be aware of? _____

_____

_____

Please mark painful or distressed areas on the diagrams below, if applicable



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

Lifestyle

Occupation _____ Employer _____

Current quality of life _____

Any unusual stress lately? _____

Any anxiety, depression or other emotional issues? If so, please describe _____

_____

How is your energy? _____ How is your appetite? _____

Any digestive issues? If so, please describe _____

Describe your daily diet _____

_____

_____

Bowel movements: How often? _____ Please note anything unusual _____

Any urination issues? _____

Do you have trouble sleeping? If so, please describe _____

Women's Health

Are you pregnant? _____□ Trying □ Maybe Birth Control _____

Number of: Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Length of cycle (days)? _____ Durations of flow? _____

Any other gyno concerns or issues? _____

_____

Age of first menses _____ Date of last menses _____ Any Menopausal Signs_____

Hysterectomy: □Yes □No Date _____ Reason _____

_____

Health History

Please list your medical history with dates. Please include any other significant illness or ailments past or current. As well as any accidents, hospitalizations, and surgeries. _____

Medications / Allergies

List all medications you are now taking or have taken in the last 3 months, including prescriptions, over the counter medications, vitamins, herbs, etc.

Name	Reason for taking	Dosage	How long

Please list all allergies: mediations, foods, environmental, etc. _____