PERSONAL HISTORY

Name__________________________________E-mail____Date_________________

Address ____ City _______________________State _______ Zip ________________

Phone (H)______________________________(W)________________________________(Cell)______________________________

Birthdate_______________Age________Sex________Height__________Weight__________ Married Single Divorced Widowed Separated

Occupation____

Main complaint(s) that brought you to this office ____

List other doctors seen for this condition ____

When did this condition begin ____ Due to accident: Yes _______ No _______

List medication/vitamins now taking and why:

1. ____
2. ____
3. ____

List any injuries, operations, or pertinent history:

1. ___________________________________Date_____________
2. ___________________________________Date_____________
3. ___________________________________Date_____________

Who referred you to our office: _____________________ _____ N.Side News _____ Brightside _____ Phonebook _____ Insurance

Who is responsible for your bill besides yourself: (check one) _____ Insurance _____ Work Comp _____ Parents _____ Other

Name, address and phone of responsible party checked above: ____

____

_________________________________ Name of person on insurance policy _________________________________ Supervisor who authorized Workman's Comp.

Instructions: Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. **Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now).**

Gastro-intestinal

Acute	Chronic	
_____	_____	Digestive complaints
_____	_____	Stomach pain
_____	_____	Ulcers
_____	_____	Frequent heartburn
_____	_____	Nausea
_____	_____	Frequent diarrhea
_____	_____	Irritable bowel
_____	_____	Hemorrhoids
_____	_____	Frequent vomiting
_____	_____	Colitis/diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder trouble
_____	_____	Frequent burping/belching

Immune Response

Acute	Chronic	
_____	_____	Frequently sick
_____	_____	Frequent swollen glands/sore throats
_____	_____	Depression and/or anxiety
_____	_____	Achy joints/muscle pain
_____	_____	Headaches/migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food allergies
_____	_____	Eczema or hives
_____	_____	Allergies (mild / moderate / severe)

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle cramps/muscle spasms
_____	_____	Neck pain
_____	_____	Jaw pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	Shoulder / elbow / wrist pain
_____	_____	Numbness/Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee pain / Hip pain
_____	_____	Joint pain or loss of function
_____	_____	Osteoporosis/Osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis/Bursitis

Cardiovascular

Acute	Chronic	
_____	_____	Irregular heartbeat
_____	_____	Heart murmur/palpitations
_____	_____	High or low blood pressure
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands and feet cold all the time

Respiratory

Acute	Chronic	
_____	_____	Chronic cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent head colds
_____	_____	Recurrent sinus infections
_____	_____	Recurrent bronchitis
_____	_____	Smoker

Genito-Urinary

Acute	Chronic	
_____	_____	Too frequent urination
_____	_____	Discolored or foul-smelling urine
_____	_____	Blood in urine
_____	_____	Recurrent kidney or bladder infections
_____	_____	Kidney stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder

Eyes/Ears

Acute	Chronic	
_____	_____	Recurrent ear infections
_____	_____	Eye infections
_____	_____	Slowly losing vision
_____	_____	Floaters in eyes
_____	_____	Glaucoma
_____	_____	Macular degeneration
_____	_____	Cataracts
_____	_____	Diabetic retinopathy

Miscellaneous

Past	Present	
_____	_____	Difficulty sleeping
_____	_____	Restless, uneasy sleep
_____	_____	Edema
_____	_____	Unusual swelling in arms or legs
_____	_____	Tobacco _____packs/day
_____	_____	Alcohol _____ drinks/day / week / month
_____	_____	Drug or Alcohol Dependence
_____	_____	Coffee/Tea/Caffeinated Soft drinks: cups/cans per day _____________

Have you or your family had:

Self	Family	
_____	_____	Cancer
_____	_____	Epilepsy
_____	_____	Chronic Back Problems
_____	_____	Chronic Headaches
_____	_____	High Blood Pressure

Endocrine (Glandular)

Acute	Chronic	
_____	_____	Cold hands and feet
_____	_____	Low blood pressure
_____	_____	Weight problems (over or under)
_____	_____	Thyroid problems
_____	_____	Diabetes
_____	_____	Irritable if meals are missed
_____	_____	Anxiety/nervousness/irritability
_____	_____	Dizzy upon standing too quickly
_____	_____	Weak and shaky
_____	_____	Hyperactive behavior
_____	_____	Depression
_____	_____	Very susceptible to infections
_____	_____	Frequent headaches
_____	_____	Digestive complaints

For Women Only

Acute	Chronic	
_____	_____	Recurrent urinary tract infections
_____	_____	Yeast infections
_____	_____	Vaginal discharge
_____	_____	Menstrual irregularity
_____	_____	Cramping
_____	_____	Mood swings/depression
_____	_____	Pre-menstrual syndrome
_____	_____	Infertility
_____	_____	Frequent miscarriages
_____	_____	Hot flashes
_____	_____	Currently taking hormone medication
_____	_____	Currently taking birth control pills
_____	_____	Lumps in breast
_____	_____	Uterine cysts/ovarian cysts
_____	_____	Bladder leaks too easily
_____	_____	Endometriosis
		Pregnancy, # of Births ______
Y	N	Birth Control Pills, Type ____________________

For Men Only

Acute	Chronic	
_____	_____	Prostate trouble
_____	_____	Urination problems
_____	_____	Reproductive problems

Self	Family	
_____	_____	Rheumatoid Arthritis
_____	_____	Diabetes
_____	_____	Heart Problems
_____	_____	Lung Problems
_____	_____	Lupus

Please read below and sign. Thank You!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I further authorize the Doctor's Office to accept assignment of insurance benefits.

Patient's Signature ____ Date ____________________

Guardian or Spouse's
Signature Authorizing Care ____ Date ____________________

HABITS

Name: ____ Date:___________________________

To help us better understand your overall health picture and to see how much your lifestyle is influencing this picture, please answer the following:

What is your occupation? ___________________________________ Do you enjoy your work? ____________

On your <u>average day</u> *(either at home or work)* how much time do you spend?

Sitting __________ Standing __________ Lifting __________ Bending __________

Do you eat Red Meat? Y N How often - ____________ day / week / month?

Do you eat in fast food restaurants? Y N How often - ____________ day / week / month?

LIQUID CONSUMPTION	Y/N	TYPE	AMOUNT	FREQUENCY
Water?				
Alcohol?				
Soda?				
Coffee?				
Tea?				
Fresh Juice?				
Canned/Bottle Juice?				
Milk?				

Frequency Of: Urination Day _______ Night_______ Any Problems? ______________________________

Bowel Movement _______ [ ] Loose [ ] Hard Any Problems? _________________________

Are you a vegetarian? Y N Type? __________________________________ For How Long? ________

Are you dieting? Y N How? ___________________________ What supplements/vitamins do you take?

____

____

What sports have your played *(past)* <u>seriously</u>? ____

Are you in training for a particular sport? Y N Which?

____

Which sports/recreation activities do you enjoy doing now? ____

Do you exercise [ ] Never [ ] Sometimes [ ] Often Type? [ ] Stretching [ ] Cardio-vascular [ ] Strength

Do you use Tobacco? Y N What? __________________ How much? ________ How long? _________

Do you have sufficient energy for your normal activities? Y N If not, explain

____

Do you wear glasses or contact lens? Y N Has your vision changed lately? Y N

How? ____

Time you go to bed? __________ Average # of hours/night? __________ Quality? _______________________

Age and type of mattress you sleep on? ____

Do you wear heel lifts or other foot supports? Y N Explain? ___________________________________

Do you use magnets on any part of your body? Y N Where? ___________________________________

Do you use an air purifier at home or office? Y N Type? ______________________________________

Do you utilize any type of stress reduction? Y N Explain? ____________________________________