GENERAL INFORMATION

Name:____ **Date of Birth**:_______/_______/_______

Age:__________ **Gender**: ○ Male ○ Female ○ Non-binary ○ Other:________________________

Height:_____________ **Weight**:_____________ **Dominant Hand**: ○ Right ○ Left

Address:____

Street City State Zip Code

Phone Number: Home (____)_____________ Mobile (____)_____________ Work (____)_____________

Occupation:____

Employer:________________________________

Marital Status: ○ Single ○ Married ○ Divorced ○ Widow ○ Partner

Race: ○ White ○ African American ○ American Indian ○ Asian ○ Native Hawiaann ○ Other:________

Ethnicity: ○ Hispanic/ Latino ○ Not Hispanic/ Latino ○ Other:______________

MEDICAL CONTACT INFORMATION

May we leave detailed voicemails? ○ Yes ○ No

Emergency Contact:____

Phone Number: Home (____)_____________ Mobile (____)_____________

Relationship:____

Other persons whom we may release medical information to:

Contact:____

Phone Number: Home (____)_____________ Mobile (____)_____________

Relationship:____

Contact:____

Phone Number: Home (____)_____________ Mobile (____)_____________

Relationship:____

INSURANCE INFORMATION

Policy Holder: ○ Myself ○ Spouse ○ Parent

Please complete only if you are NOT the policy holder

Name:____

Phone Number:(____)_____________

Relationship to Policy Holder:____

Birthdate of Policy Holder:________/__________/_________

Address of Policy Holder:____

Employer of Policy Holder: ____

HEALTHCARE INFORMATION

Primary Care Physician:____

Phone Number:(____)_____________

Address:____

Street City State Zip Code

Referring Physician: ______________________________

Phone Number:(____)_____________

Address:______________________________

Street City State Zip Code

Please list all other physicians you are currently seeing and why you see them:

Doctor:	Reason:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

CURRENT PROBLEM

Please describe your current problem including how and when it began:

____

____

____

____

____

How long does it last?______________________________

Does anything trigger these symptoms?______________________________

Is this problem work related?______________________________

Is this problem accident related?______________________________

What medications have you tried? ______________________________

____

Have you done any Therapy (OT / PT)? How long? ______________________________

____

Please list all of the testing (EEG, EMG, MRI, CT, CTA) you have done with approximate dates and locations

Test:	Location / Date:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please list all hospitalizations you have had (associated with this problem) with approximate dates and locations

Test:	Location / Date:

ALLERGIES:

Please list ALL medication and environmental allergies and their associated reactions

Allergy:	Reaction:

CURRENT MEDICATIONS:

PLease list ALL medications you are CURRENTLY taking. This includes prescribed medications, dietary supplements, vitamins, injections, herbal supplements, inhalers, etc.

Medication Name:	Dose:	Frequency:

SURGICAL HISTORY

Surgery: ______________________

Surgeon / Date: ______________________

WOMEN'S HEALTH

Are you pregnant, trying to become pregnant or breastfeeding? ○ Yes ○ No

FAMILY HISTORY

Mother: Deceased ○ Yes ○ No
Cause of Death:
Age:______________________

Father: Deceased ○ Yes ○ No
Cause of Death:
Age:______________________

Maternal Grandparents: ______________________

Paternal Grandparents: ______________________

Children: ______________________

Siblings: ______________________

SOCIAL HISTORY:

Do you use tobacco products? ○ Yes ○ No
○ Cigarettes ○ Chew/ Dip ○ Cigars ○ Vape ○Other:______________________
How many per day?______________________ **or Per week?**______________________

Do you drink alcohol? ○ Yes ○ No
○ Beer ○ Wine ○ Liquor ○Other:______________________
How many drinks per day?______________________ **or Per week?**______________________

Do you use recreational or street drugs? ○ Yes ○ No
○ Marijuana ○ Opioids ○ Cocaine ○ Meth ○ Other:______________________

Who do you live with?______________________

MEDICAL / PHYSICAL CONDITIONS

Please check all that apply

○ Anxiety
○ ADD/ADHD
○ Adrenal Gland Disorder
○ Auto-Immune Disease
Type:
○ Balance Problems
○ Bipolar Disorder
○ Bladder Problems
○ Bleeding Disorder
○ Blurred Vision
○ Cancer
Type:
○ Congestive Heart Failure
○ Coronary Artery Disease
○ Cerebral Vascular Accident (CVA)
○ Carpal Tunnel Syndrome
○ Celiac Disease
○ Chronic Fatigue
○ Concussion(s)
○ Dementia
○ Deep Vein Thrombosis (DVT)
○ Diabetes
Type:
○ Depression
○ Dizziness/ Vertigo
○ Ehlers Danlos Syndrome
○ Ear infections
○ Fibromyalgia
○ Food Sensitivities
○ Gout
○ Guillain Barre Syndrome
○ Huntington's Disease
○ Heart Arrhythmias (A-fib, etc.)
○ Hashimoto's Disease
○ Heart Disease
○ Heart Attack (MI)
○ Hepatitis A, B, C, D, E
○ Hyperlipidemia (high cholesterol)
○ Herpes
○ Hypertension (high blood pressure)
○ HIV/ AIDS
○ Immune Deficiency
○ Insomnia
○ Kidney Disease
○ Leaky GUt Syndrome
○ Lung Disease
○ Light Sensitivity
○ Migraine
○ Motion Sickness
○ Multiple Sclerosis
○ Myasthenia Gravis
○ Osteoporosis
○ Parkinson's Disease
○ Peripheral Vascular Disease
○ Ringing in Ears
○ Sound Sensitivity
○ STI/ STDs
Type:
○ Seizures
○ Stroke
○ Thyroid Disease
○ Traumatic Brain Injury
○ Tremors / Involuntary Movements
○ Tuberculosis
○ Urinary Tract Infections (UTI)
○ Ulcerative Colitis

ADDITIONAL COMMENTS

Please use the space below

The above mentioned is my complete medical and social history. By signing below I consent to treatment.

Patient Signature:____ Date:______/_______/_______

Print Name: ____ Date of Birth:______/_______/_______

Signature of Legal Guardian or Representative:____
Date:_____/______/______

Print Name:____