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Important Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

***All** information is strictly confidential*

Date _____ Name _____

Address _____ City _____

State _____ Zip _____

E-mail address _____

Cell Phone _____ Home Phone _____

Age ____ Date of Birth _____

Guardian (if under 18) _____

Gender ❑ M ❑ F

Significant Other _____

Occupation _____ Employer _____

Employer Address _____ City _____

State _____ Zip _____

Insurance Company_____Contact #_____

ID # _____

How did you hear about our office? _____

What are the main health problems for which you are seeking treatment? _____

_____

What other forms of treatment have you sought? _____

_____

Other physicians/therapists seen for this condition:_____

_____

List any other health problems you now have:_____

_____

List any allergies, food sensitivities or food cravings that you have: _____

_____

List any accidents, surgeries, or hospitalizations (include date):_____

_____

Lab Results (please include copies): _____

Have you received acupuncture before? ❑ Yes ❑ No Date _____ For _____

Have you received chiropractic before? ❑ Yes ❑ No Date _____ For _____

Please mark Yes or No to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	❑	❑	Epilepsy	❑	❑	Psychiatric Care	❑	❑
Alcoholism	❑	❑	Herpes	❑	❑	Rheumatic Fever	❑	❑
Cancer	❑	❑	High Cholesterol	❑	❑	Stroke	❑	❑
Diabetes	❑	❑	Infections	❑	❑	Tuberculosis	❑	❑
Heart Disease	❑	❑	Osteoporosis	❑	❑	Tumors, Growths	❑	❑
High Blood Press.	❑	❑	Pacemaker	❑	❑	Ulcers	❑	❑
Hepatitis	❑	❑	Prostate Problem	❑	❑	Venereal Disease	❑	❑

Other _____

Exercise	Work Activity	Habits	
❑ None	❑ Sitting	❑ Smoking	Packs/Day _____
❑ Moderate	❑ Standing	❑ Alcohol	Drinks/Week _____
❑ Daily	❑ Light Labor	❑ Coffee/Caffeine	Cups/Day _____
❑ Heavy	❑ Heavy Labor	❑ High Stress Level	Reason _____

Medications	Dosage	Reason	How Long?

Vitamins, herbs, homeopathics	Dosage	Reason	How Long?

Date of last: MRI/CT/Bone Density Scan _____

Physical Exam_____ Blood Test _____

X-Ray _____ Urine Test _____