Patient Name: ____

Last Name First Name Middle Initial

What is your preferred first name? ____

DOB: ______________________________ SSN:__________________________________

Address: ____

City: ____________________ State: ______ Zip Code: ___________

Email address: ____

Phone:

1. □ Cell □ Home □ Work: (_____)_______________ Confidential voicemail OK? Yes No

2. □ Cell □ Home □ Work: (_____)_______________ Confidential voicemail OK? Yes No

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The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Your answers are both voluntary and private.

What is your birth sex? □ Male □ Female □ Unknown □ Another: _______________

What gender do you identify as? □ Male □ Female □ Trans □ Another: _______________

What is your pronoun? □ He □ She □ They □ Another: _______________

Housing status: □ Not Homeless □ Homeless □ At Risk □ Other

Employment Status: □ Full Time □ Not Employed □ Part Time □ Retired □ Seasonal □ Self-Employed □ Student (Full Time) □ Student (Part Time)

Occupation: _________________ Hours per Week: ____________________ Employer: ___________________

Marital Status: □ Single □ Married □ Significant other □ Widowed

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Primary Care Provider (PCP) Information (Please select one of the following):

□ I wish to establish Primary Care

□ I am seeking adjunctive care only, my PCP is:____________________________________

Who else is on your health care team? ____

____

Financial and Insurance Information:

Person who is financially responsible for the account:

Name: ______________________________ Relationship to the patient: ____________________

Address (if different from patient): ____

City: _____________________ State: _______________________ Zip: ___________________

Emergency Contact Name: ____

Relationship: ____

Legal Guardian? □ Yes □ No

Primary Phone: ___________________________Work Phone: _________________________

Please provide your insurance information below:

Primary Insurance Company: ____

Group # ________________________________ Member ID #___________________________

Relationship to Subscriber:____

Claims Address: ____

Subscriber Name (if other than patient):_______________ DOB: ________________________

Secondary Insurance Company: ____

Group # ________________________________ Member ID#___________________________

Relationship to Subscriber:____

Claims Address: ____

Subscriber Name (if other than patient):_______________ DOB: ________________________

Check if applicable: □ Auto Accident □ Workers compensation

Date of Accident: ____________ Claim#:____________________________

I certify the above information is true and correct to the best of my knowledge. I acknowledge that I am financially responsible for payment of all services rendered, and that I am subject to all terms on the financial consent form.

____ ______________________________

Signature Date

Personal Health History

Patient Name: ____ Date of Birth: ______________________

What are your top three health goals? (*Please elaborate as much as possible, use extra pages if necessary)*

1. ____
____
____
____

2. ____
____
____
____

3. ____
____
____
____

Allergies:

□ Sulfa □ Penicillin □ Aspirin □ Codeine □ Dogs □ Cats □ Mold □ Dust □ Bees □ Pollen □ Sulfites □ Latex
□ Wheat □ Shellfish □ Peanuts □ Eggs □ Milk □ Soy

□ Other____

Medications: Please list all medications, over-the-counter medications, vitamins, or other supplements

Name of Medication/ Supplement	Dose	Frequency Taken

Medical Conditions: Current and Historical

□ Adrenal Disorder
□ Anemia
□ Anxiety
□ Arthritis/Joint Disorder
□ Asthma
□ Cancer
□ COPD
□ Depression
□ Diabetes Mellitus
□ Digestive Problem
□ Heart Disease
□ High Cholesterol
□ High Blood Pressure
□ Sleep apnea
□ Inflammatory Bowel Disease
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Liver Disease
□ Stroke
□ Thyroid Disease
□ Other: ___________

Surgeries / Hospitalizations:

□ Appendectomy
□ Brain Surgery
□ Breast Surgery
□ CABG
□ Cholecystectomy
□ Colon Surgery
□ Cosmetic Surgery
□ C-Section
□ Eye Surgery
□ Fracture Surgery
□ Hernia Repair
□ Hysterectomy
□ Joint Replacement
□ Prostate Surgery
□ Small Intestine Surgery
□ Spine Surgery
□ Tonsillectomy
□ Tubal Ligation
□Valve Replacement
□ Vasectomy
□ Other: ___________________

	No Known problems	Alcohol / Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems	Other
Mother															
Father															
Sister															
Brother															
Maternal Grandma															
Maternal Grandpa															
Paternal Grandma															
Maternal Aunt															
Maternal Uncle															
Paternal Aunt															
Paternal Uncle															
Other															

□ Adopted □ Family History Unknown

Personal History

Tobacco: □ Never Used □ Used from age ______ to ______, _______ packs per day.

Marijuana: □ Never Used □ Used from age ______ to ______, ________ times per day.

Alcohol: □ Never Used □ Drinks per day ______

Other mind altering substances: □ Never Used □ Type: ______________ □ Frequency: ___________

Comments:

Sexual activity: □ Currently □ Not currently □ Never

Birth Control Method: ____

Partners: □ Male □ Female □ Both □ Another

Comments:

Diet: *Please describe a typical day*

Breakfast:

Lunch:

Dinner:

Snacks: (and time of day)

Beverages:

What foods do you avoid and why?

Sleep: Bedtime ______ Wake up time ______

□ Difficulty falling asleep □ Difficulty staying asleep □ Snoring □ Difficulty breathing

Bedtime habits / sleep hygiene:

____

____

Do you feel rested upon waking? ____

How does your mood impact your life / function?

____

What is your usual energy level? ____

Changes in weight? ____

Disordered Eating (current or historical)? ____

Do you exercise? If so, what do you do for exercise and how often?

____

____

What are your major stressors?

____

____

Do your work or hobbies expose you to toxic chemicals, heavy metals, mold, or second hand smoke?

____

Do you feel safe in your home? ___________ Do you feel safe at work / school? ___________________

Have you recently or currently considered suicide? ____

Have you struggled with addiction? _______________ Is this something you would currently like help with? ____

Review of Systems:

Skin/Hair	□ Acne	□ Dandruff	□ Ridged nails	□ Itching
	□ Dryness	□ Hair loss	□ Spoon shaped nails	□ Eczema
	□ Moles	□ Unusual hair growth	□ Athlete's foot	□ Hives
	□ Lumps	□ Cold sores	□ Burning feet	□ Psoriasis
	□ Easy bruising	□ Slow healing	□ Sores	□ Warts
	□ _____________			

Eyes	□ Blurred vision	□ Glaucoma	□ Watering	□ Redness
	□ Double vision	□ Light sensitive	□ Burning	□ Infections
	□ Cataracts	□ Floaters	□ Itching	□_________

Ears	□ Excess wax	□ Sound sensitive	□ Infections	□ Hearing voices
	□ Hearing loss	□ Ringing	□ Vertigo	□ Earaches
	□ Itching	□ Pressure	□ __________	

Nose	□ Congestion	□ Nose bleeds	□ Itching	□ Allergies
	□ Post-nasal drip	□ Runny nose	□ Polyps	□ Frequent colds
	□ Loss of smell	□ __________		

Mouth/Throat	□ Cold sores	□ Ulcers	□ Bad breath	□ Trouble swallowing
	□ Sore tongue	□ Bleeding gums	□ Amalgams	□ Dentures or bridges
	□ Implants	□ Braces	□ Root canals	□ Gingivitis
	□ Teeth Clenching	□ Grinding teeth	□ Mouth infections	□ _____________
	□ Sore throat	□ Difficulty swallowing	□ Hoarseness	□ _____________

Last Dentist Visit: ____

Findings: ____

Lungs	□ Cough	□ Shortness of breath	□ Phlegm	□ Wheezing
	□ Sleep apnea			

Heart	□ Chest pain	□ Chest tightness	□ Palpitations	□ Cold limbs
	□ Swelling	□ High BP	□ Low BP	□ Murmurs
	□ Varicose Veins	□ _________	□ _________	

Digestion	□ Bloating	□ Nausea	□ Side pain	□ Cramps
	□ Excess gas	□ Vomiting	□ Anal itching	□ Burning
	□ Excess belching	□ Hard to swallow	□ Hemorrhoids	□ Indigestion
	□ Heartburn	□ Ulcers	□ Change in appetite	

Bowel	How often? _______		
Movements	□ Blood	□ Mucus	□ Undigested food
	□ Loose stool	□ Dry stool	□ Diarrhea

Urinary	□ Burning	□ Incontinence	□ Stones	□ Frequency
	□ Infection	□ Recent change	□ Urgency	□ Hesitancy
	□ Odor	□ Pain	□ Discharge	
	__ # of times at night	□ ____________	□ __________	

Genital	□ Discharge	□ Infection	□ Pain w/ sex
	□ Impotence	□ Hernia	□ Genital Herpes
	□ Itching	□ Testicular mass	□ Sores / ulcers

Menses	□ PMS	□ Itching	___ Age menses began	Menstrual blood:
	□ Irregular cycle	□ Discharge	____ # times pregnant	□ Dark
	□ Pain w/ menses	□ Infections	____ # live births	□ Clots
	□ Excess flow	□ Dryness	____ # miscarriages	□ Pale
	□ Spotting	□ Hot flashes	____ # abortions	___ avg days of flow
				___ avg cycle length

Date of last Menses: _____________

Musculoskeletal	□ Arthritis	□ Spasms	□ Limited motion	□ Weakness
	□ Back pain	□ Rigidity	□ Atrophy	□ Joint swelling
	□ Stiffness	□ Flaccidity	□ Many fractures	□ __________
	□ _________			

Neurologic	□ Depression	□ Memory loss	□ Fatigue	□ Fainting
	□ Anxiety	□ Learning probs	□ Headaches	□ Tics
	□ Confusion	□ Hyperactivity	□ Numbness	□ Seizures
	□ Mood swings	□ Restlessness	□ Tingling	□ Autism spectrum
	□ Nervousness	□ Insomnia	□ Nerve pain	□ Apathy
	□ Sleepiness	□ ADD/ ADHD	□ ___________	□ ______________

Endocrine	□ Swelling	□ Heat intolerance	□ Hypothyroid	□ Excess sweat
	□ Fatigue	□ Cold intolerance	□ Hyperthyroid	□ Hot flashes
	□ Very thirsty	□ Weight probs	□ Diabetic (I or II)	□ Hormone replacement
	□ Very hungry	□ Low blood sugar	□ Transgender	□ __________________

Immunity	□ Recurring illness	□ Chemical sensitivity	□ Cancer (type)	____________
	□ Swollen glands	□ Autoimmune	□ Chronic fatigue	
	□ Multiple allergies	□ ______________	□ ____________	