New Patient Form

Information provided on this form is confidential. Please print legibly.

Today's Date: _______/______/_______
Name: ____
Sex: □ Male □ Female Date of Birth: _______/_____/______ Age:_______
Address:____
City:______________________State:_________________ Zip:_________________
Occupation:________________________________ Email address:______________________________
Telephone: Cell:____________________Home:_____________________Work:______________________
How did you hear about us?:____

Main problem(s) you would like us to help you with:_______________________________________
____
How long have you had this condition?_____________________The onset was: □ sudden □ gradual
Date of last physical exam: _______/_____/______ Physician:__________________________
Medical diagnosis, if any?____
What treatments have you tried?____

Medicines/Supplements: Please check any of the following that you are now taking:

□ Aspirin or Ibuprofen	□ Antidepressants	□ Antacids	□ Oral Contraceptives
□ Diet Pills	□ Laxatives	□ Sleeping Pills	□ Allergy Medication
□ Cold / Flu Medication	□ Vitamins	□ Herbs	□ Other

List all Vitamins and Medications currently using:
____
____
____
____

Past Medical History: Please check any or all that apply:

□ AIDS/HIV	□ Heart Disease	□ Pacemaker	□ Alcoholism
□ Hepatitis A/B/C	□ Seizures	□ Allergies	□ Herpes
□ Stroke	□ Asthma	□ Lyme Disease	□ Thyroid Disorder
□ Cancer	□ Multiple Sclerosis	□ Latex Allergy	□ Diabetes
□ Musculo-skeletal disorder	□ Lymph nodes removal	□ Emphysema	□ Organ Transplant

□ Other/Comments:____
Describe any significant injuries, surgeries, or major illnesses:____________________________________
____

Emotions and Sleep: CHECK current symptoms. CIRCLE symptoms that have affected you in the past:

□ Poor memory	□ Nervousness	□ Difficulty concentrating	□ Fearfulness
□ Anxiety □ Depression	□ Frequent sighing	□ Anger, irritability, frustration	□ Obsessive thoughts
□ Suicidal thoughts	□ Panic attacks		

□ Other: How do you feel emotionally?:____

□ Married/Stable Relationship □ Single □ Divorced □ Widowed
How do you feel about your relationship?____

Urinary & Genital:

I urinate approximately?______times per day. Color: □ pale yellow □dark yellow/brown/orange

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past:

□Trouble starting stream □ Dribbling when sneezing / coughing □ Frequent urination
□ Incontinence □ Frequent urinary tract infections □ Blood in urine
□ Painful urination □ Kidney stones □ Other:_____________

How is your sexual energy?____

What kind of birth control do you use?____

Do you have (check all that apply):

□ Infertility □ Pain during sexual relations □ Other:___________________________

Women:

Are you *currently* pregnant? □Yes □ No Are you *presently* trying to get pregnant? □Yes □ No

At what age did you start menstruating?_______

Number of pregnancies?______Number of deliveries?________Abortions / Miscarriage(s)?___

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

□ High Blood Pressure □ Low Blood Pressure □ Chest Pain □ Phlebitis
□ Varicose veins □ Poor circulation □ Palpitations □ Irregular heartbeat

Skin and Hair:

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past.

□ Dry skin □ Hives □ Bruise easily □ Skin rashes
□ Psoriasis □ Premature graying □ Itching □ Eczema
□ Hair loss □ Acne □ Night sweating □ Excess sweating
□ Changes in moles or lumps □ Other:____

Muscles, Joints and Bones:

Do you have pain or tightness?________Where?___________________________________

What is the current level of pain, from 1-10?___The pain feels worse with: ____________

The pain feels better with: _________________________The pain is: please check all that apply:

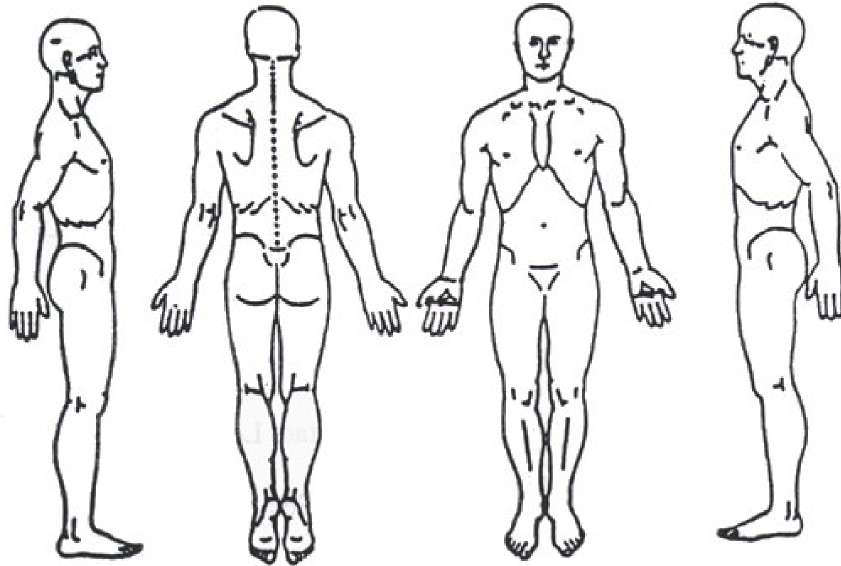
□ Sharp □ Dull □ Superficial □ Deep
□ Tingling □ Numb □ Burning □ Aching
□ Fixed □ Moves around □ Other:___________________________

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

□ Swollen joints □ Tendonitis □ Arthritis/joint pain □ Rheumatism
□ Bone pain □ Muscle cramps/pain □ Repetitive strain injury □ Weak muscles
□ Spinal curvature □ Other:____

On the following diagram, please SHADE in the areas that you would like to be addressed.
KEY: USE LETTERS TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE
B = BURNING
P = PINS & NEEDLES
S = STABBING
N = NUMBING
O = OTHER



____ _______________________

Patient or Guardian Signature Date