Welcome!

Please complete this form to the best of your ability, filling in all applicable information. If you have any questions or concerns, please do not hesitate to ask.

Patient Information

Full Name: ____ Name you would like to be called: ___________

Date of Birth: _____/_____/______ Sex: Female Male

Address: ____ Apartment/Suite #: ___________

City: ___________________________________ State: ________________ Zip: ____________

Home Phone: _____-_____-______ Work Phone: _____-_____-_____ext: ____ Cell Phone: ____-_____-_____

E-Mail Address: _________________________________@__________.______

Do you prefer to receive phone calls at: Home Work Cell Any

Type of Work: ____

Are you: Married Single

Spouse's Full Name: _________________________________ D.O.B.: _____/_____/_____

With whom may we discuss your medical care with? ____

To whom may we thank for referring you to us? ____

Patient Case History

Health Goals/Health Concerns-
Please check the reasons why you are here:

	ADD/ADHD		Liver/Gall Bladder Symptoms		Small Intestine/Pancreas Symptoms
	Allergies		Lose Fat		Stomach/Gastritis/Ulcer Symptoms
	Anxiety/Panic Attacks		Lyme Disease Symptoms		Eventually stop taking "lifestyle" Rx
	Arthritis Symptoms		Increased Energy		(ie: high blood pressure, cholesterol, etc.)
	Asthma Symptoms		Maintain/Gain Muscle Mass		Other:
	Better Sleep		Male Reproduction Symptoms		
	Brain Function Improvement		Menopausal Symptoms		
	Cancer Support		Migraine Symptoms		
	Change Life Style		Osteoporosis Symptoms		
	Circulation Symptoms		Peripheral Neuropathy Symptoms		
	Colon Symptoms		Pre-Menstrual Symptoms		
	CRS "Can't Remember Stuff!"		Prostate Symptoms		
	Depression		Respiratory Allergies		
	Diabetes		Skin Problems		

Health History-

Do you or have you ever had the following? (please check all that apply)

	AIDS/HIV		Chicken Pox		Hepatitis		Numbness/Tingling		Stroke
	Alcoholism		Cold Sores		Hernia		Osteoporosis		Suicidal
	Allergy Shots		Depression		Herniated Disc		Pacemaker		Swollen Joints
	Anemia		Diabetes		Herpes		Parkinson's		Thyroid
	Anorexia/Bulimia		Difficulty Breathing		High Cholesterol		Pinched Nerve		Tonsillitis
	Appendicitis		Difficulty Chewing		Blood Pressure		Pneumonia		Tuberculosis
	Arthritis		Asthma		Ear Problem		Liver Problems		Poor Circulation
	Bleeding Disorder		Emphysema		Loss of Sleep		Prostate Problems		Ulcers
	Breast Lump		Epilepsy		Measles		Prosthesis		Vaginal Infection
	Bronchitis		Fatigue		Migraines		Psychiatric Care		Venereal Disease
	Bursitis		Glaucoma		Miscarriage		Rheumatoid Arthritis		Varicose Veins
	Cancer		Goiter		Mononucleosis		Rheumatic Fever		Whooping Cough
	Cataracts		Gout		Multiple Sclerosis		Scarlet Fever		Other:
	Chemical Dependent		Headache		Mumps		Sciatica		
	Chest Pain		Heart Problems		Neck Pain		Sinus Problems		

Habits

Smoke	Yes	No	Packs/Day	______ / Day
Alcohol	Yes	No	Cups/Day	______ / Day
Coffee	Yes	No	Cups/Day	______ / Day
Soda	Yes	No	Cups/Day	______ / Day
Exercise	Yes	No	How often?	______ X Week
Vitamins	Yes	No	What kind? Please list below:	

Women

Are you Pregnant?	Yes	No
Are you Nursing?	Yes	No
Are you on Birth Control?	Yes	No

Family History

Mother - Living Yes No

Diabetes

Heart Problems

Kidney Problems

Cancer

Back Problems

Arthritis

Blood Pressure Problems

Father - Living Yes No

Diabetes

Heart Problems

Kidney Problems

Cancer

Back Problems

Arthritis

Blood Pressure Problems

Siblings - # ____ Living Yes No

Diabetes

Heart Problems

Kidney Problems

Cancer

Back Problems

Arthritis

Blood Pressure Problems

Have you ever had any fractures or dislocations?

Yes No If yes, please list

What	When

Have you ever had any surgeries performed?

Yes No If yes, please list

What	When

Are you currently taking any Rx Medicines?
Yes No If yes, please list

Name of Medicine	For What Condition

Do you regularly take "Over the Counter" Medicines?
Yes No If yes, please list

Name of "OTC" Medicine	For What Condition

Nutritional Recommendations

Any Nutrition Recommendations are provided solely to support the physiological and biochemical processes of the human body and are not meant to diagnose, treat, cure or prevent any disease or condition.

Read and follow all supplied product literature and container labels thoroughly.

We will gladly return unopened products within 30 days of purchase.

I acknowledge receipt and understanding of the above.

Patient Signature: ____ Date: ____/____/____