First Name: __________________ MI: ____ Last Name: _____________________ Date: ____________

Address: __________________________________ City: _____________ State: ______ Zip: _________

Home Phone: ________________ Cell Phone: __________________ Email: _______________________

Interested in appointment reminders? If yes, do you prefer ______Email _______Text
(*Either option will be sent to you 2 hours prior to each appointment)* Phone Carrier ____________

Date of Birth: __________________ Age: _______ Sex: M F Are you pregnant: Yes No

If pregnant: planned place of birth: ____________ Provider: ___________ Expected due date: _______

SSN: __________________ Employed by: ___________________ Occupation: ____________________

Marital Status: _____________ Spouse's Name: ________________ Children? Yes No Ages: ________

In case of emergency, please notify: _______________________________ Phone: __________________

How did you find out about our office? ___________________________

If you were referred to our office, whom may we thank? _________________________

PLEASE READ: The purpose of today's consultation is to determine which test(s) may be most beneficial to your health. Your file will be carefully analyzed and you will receive a personalized recommendation.
The fee for today's consultation is $105 (unless special arrangements have been previously discussed) and will be due today.

PLEASE INITIAL HERE indicating that you have read and understand this section: _____________

WHY THIS FORM IS IMPORTANT

Our focus is on assisting clients to function optimally, for them to become more self-aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. **Please complete this form as thoroughly as possible** and the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness check this box) ☐

Health Concern(s): ______________________ ______________________

Other professionals seen for this: ______________________ ______________________

Treatment and results: ______________________ ______________________

Other health concerns: Please note all other health concerns present or in the past.
Please check box applicable

☐ Allergies	☐ Frequent colds	☐ Dizziness/Lightheadedness
☐ Loss of balance	☐ Difficulty concentrating	☐ Fatigue
☐ Indigestion	☐ Heartburn	☐ Bloating
☐ Appendicitis	☐ Asthma	☐ Bronchitis
☐ Emphysema	☐ Pneumonia	☐ Bleeding disorders
☐ Cancer	☐ Cataracts	☐ Vision changes
☐ Diabetes	☐ Hypoglycemia	☐ Epilepsy
☐ Heart Disease	☐ Hypertension	☐ Headaches
☐ Migraines	☐ High Cholesterol	☐ Hepatitis
☐ Difficult digestion	☐ Constipation	☐ Loose Stools
☐ Hernia	☐ Herniated Disc	☐ Kidney Disease
☐ Liver Disease	☐ Fertility Problems	☐ Miscarriage
☐ Multiple Sclerosis	☐ Osteoarthritis	☐ Rheumatoid Arthritis
☐ Osteoporosis	☐ Numbness and tingling	☐ Pinched Nerve
☐ Pins and Needles	☐ Parkinson's Disease	☐ Prostate problems
☐ Stroke	☐ Menstrual Pain and Cramping	☐ Hypothyroid
☐ Hyperthyroid	☐ Urinary Tract Infections	☐ Tonsillitis
☐ Yeast Infections	☐ Ulcerative Colitis	☐ Ulcers
☐ Sleeping Problems	☐ Irritable Bowel Syndrome	☐ Restless Legs
☐ Moody/Irritable	☐ Sexual Dysfunction	☐ High Blood Pressure
☐ Muscle Tension	☐ Menopausal Difficulties	☐ Stress
☐ Anxiety	☐ Seizures	☐ Sensitive to Smells
☐ Depression	☐ Inflammation	☐ Sleep Apnea
☐ Fibromyalgia		
☐ Other: ___________________		☐ Other: ____________________

#2 Physical Stresses

Any significant injuries, falls or traumas during infancy, childhood or adulthood? **Yes No Unsure**

Have you had any surgeries, fractures, accidents? **Yes No Unsure**

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**

Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**

What is your usual exercise routine? ____

#3 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes No**

If yes, please indicate what you are taking and why

_________________________________ _____________________________________

_________________________________ _____________________________________

Do you have a history of antibiotic use? **Yes No**

If yes, how many rounds of antibiotic use? ________________

Date of last antibiotic? _________________

Are you currently taking supplements? **Yes No**

If yes, which ones and why?

_________________________________ _____________________________________

_________________________________ _____________________________________

Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**

Do you smoke? **Yes No Quit**

Do you drink? **Yes No**

Do you drink bottled water? **Yes No Occasionally**

Any known allergies, environmental or food? **Yes No**

Do you eat organic? **Yes No Occasionally**

Do you limit sugar in your diet? **Yes No**

Do you limit artificial sweeteners (i.e. aspartame, sucrose, etc) **Yes No**

Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes No** ____

Do you drink or bathe and/or shower in chlorinated/fluorinated water? **Yes No**

Do you have amalgam fillings in your mouth? **Yes No Unsure**

#4 Mental/Emotional Stresses

As psychological stress has been shown to negatively affect many systems, please let us know how you are coping with life's stresses. (Rank from 1 to 10 with 1 being minimal to 10 being extreme)

Life in general I feel _____

Work and Career I feel _____

Relationships I feel _____

Financial stress I feel _____

Time management I feel _____

Sports & hobbies I feel_____

Health and well-being I feel _____

Quality of sleep I feel _____

If you are experiencing significant or ongoing stress please explain ______________________________

____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes No** Explain: _________________________________

#5 Family Health History

Please note any health issues that are present with family members such as parents, siblings, or children.

□ Cancer

□ Hypertension

□ Stroke

□ Arthritis

□ Kidney Disease

□ Dementia

□ Diabetes

□ Thyroid Problems

□ Other: ___________________