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PERSONAL INFORMATION DATE: _____

Name _____Home Phone ( ) _____ Cell ( )_____

Email: _____ How often do you check your email?_____ Social Security #_____

Address _____ City _____ State _____ Zip code _____

Age _____ Birthdate _____ Gender at birth: M / F Height _____ Weight _____ Number of Children _____

Marital Status: * Single * Married * Widowed * Separated * Divorced *Partnered * Student: * Yes * No

Occupation _____ Employer _____ Work Phone (___)_____

Emergency Contact _____ Phone (___)_____ Relationship _____

Primary Care Physician (PCP) _____ Phone ( )_____

Date of Last Physical Exam _____ How did you of hear me? □ Insurance Company, □ My website,

□other:_____

PERSONAL HEALTH HISTORY

Please mark *'X'* for current conditions and *'P'* for past conditions you have or have had

GENERAL SYMPTOMS/ILL-NESSES
__ Seizures
__ Dizziness
__ Fainting
__ Fibromyalgia
__ Headache
__ Nervousness
__ Numbness
__Wheezing
__ Diabetes
__ Autoimmune Disease
__ Ehler's Danlos
__Cancer: _____

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__Shoulder Problems
__ Arm Problems
__ Hip Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__Rheumatoid Arthritis
__Psoriatic Arthritis
__Gout
__Osteoarthritis
__Osteoporosis
__Osteopenia
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains: what?_____
__ Broken Bones: what?_____

CARDIO-VASCULAR
__ High Blood Pressure
__Congestive Heart Failure
__ Heart Attack
__ Chest pain
__ Poor Circulation
__ Heart Murmur
__ Heart Trouble
__ Rapid Heart rate
__ Slow Heart rate
__ Stroke
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Enlarged Thyroid
__Hashimoto's Thyroiditis
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis
__ Hypothyroidism
__ Hyperthyroidism

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods

__ Vaginal Discharge
__ Breast Pain

Pregnant at this Time: □ Yes □ No

Please list all **allergies** including allergies to medications _____

List all **medications** you are presently taking (***including vitamins & supplements***) _____

_____

Indicate all **surgeries** you have had: □ NONE □ Appendix □ Tonsils □ Hernia □ Gallbladder □ Uterus □ Tubes Tied

□ Heart □ Oral □ Back/neck □ Knee □ Shoulder □ Hip List other surgeries: _____

List other **hospitalizations**_____

Have you ever been in a motor vehicle accident? * Yes * No. If yes, when? _____. Where you hurt? * Yes * No.

Please briefly describe your injuries, if applicable: _____

Please describe any other serious injuries you have had. Provide a year and a description of what body part was hurt, and what care, if any, you received: _____

_____

Do you have a Living Will or Advance Directive? □ Yes □ No

In an emergency would you want CPR? □ Yes □ No

In an emergency would you want life support? □ Yes □ No

SOCIAL HISTORY

Do you drink alcoholic beverages? □ Yes □ No If yes, what? _____ How much per week?_____

Do you smoke? □ Yes □ No If so, how many packs per day: ____

Do you consume caffeine? □ Yes □ No If yes, how much per day:_____

Do you exercise? □ Yes □ No If yes, what type of exercise? _____ How often: _____

What are your hobbies?_____

How many hours each day (at home or at your job) are you: lifting ____ sitting ____ bending ____ at a computer _____

Pediatric Records: (under 17) Are your immunizations up to date? □ Yes □ No (Please provide complete immunization record)

FAMILY HEALTH HISTORY __

Mark boxes for family members who have/had any of the following (***F****=father;* ***M****=mother;* ***S****=sister;* ***B****=brother;* ***O****=other*):

___Cancer ___Diabetes ___Heart Disease ___High Blood Pressure ___Stroke ___Epilepsy

___Chronic Headaches ___Lung Problems ___Rheumatoid Arthritis __Autoimmune Disease(s) ___Alcoholism

Other _____

I certify that all the above personal health information is complete and accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient (or Guardian) Signature _____ Date _____