



1. Please enter your information.

First Name:	Middle Initials:	Last Name:	Date of Birth:
_____	_____	_____	_____
Gender:	Marital Status:		
<input type="radio"/> Female <input type="radio"/> Male	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Domestic Partner <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed		
Street Address:	Apt./Unit #:	City:	State: Zip Code:
_____	_____	_____	_____
Mobile Phone:	Home Phone:	Work Phone:	
_____	_____	_____	
Email:	Preferred contact method:		
_____	<input type="radio"/> Mobile Phone <input type="radio"/> Home Phone <input type="radio"/> Work Phone <input type="radio"/> Email		

2. We are glad you are here! It helps us greatly to know how patients hear about us. Please choose an option below.

- | | | |
|---|--|--|
| <input type="radio"/> Internet Search | <input type="radio"/> Social Media | <input type="radio"/> Friend Family |
| <input type="radio"/> Magazine/Newspaper | <input type="radio"/> TV/Radio | <input type="radio"/> Attended and Event |
| <input type="radio"/> Chiropractor | <input type="radio"/> Physician/Nurse Practitioner | <input type="radio"/> Other Medical Provider |
| <input type="radio"/> Drive By | <input type="radio"/> Attorney | <input type="radio"/> Employee |
| <input type="radio"/> Chamber of Commerce | <input type="radio"/> Other | |

3. Emergency Contact

Name of Emergency Contact

Phone Number of Emergency Contact

4. Women

- | | | |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Breast conditions |
|------------------------------------|-----------------------------------|--|

If "other", please specify

5. Personal Information

Your Height Feet:

Your Height Inches:

Weight (in pounds):

6. Do you have any allergies?

Yes

No

7. Are you currently taking any medication(s)?

Yes

No

8. Please provide a list of your current medication(s).

Medication	Dosage	How long have you been taking it?
1.		
2.		
3.		
4.		
5.		
6.		

Other:

9. What is your main reason for today's visit?

Neck Pain

Back Pain

Right Knee Pain

Left Knee Pain

Right Hip Pain

Left Hip Pain

Right Arm/Shoulder/Elbow Pain

Left Arm/Shoulder/Elbow Pain

Right Foot/Ankle Pain

Left Foot/Ankle Pain

TMJ

Aesthetics Services

Biote Bioidentical Hormone Therapy

Weight Loss

Other

10. How long have you had the condition(s) about which you are consulting us? (Please use NA if it does not apply)

11. Please indicate the overall intensity of your symptoms:

Mild

Moderate

Severe

Very severe

12. Give details and symptoms of the above conditions. (When were you diagnosed, frequency, what makes symptoms better or worse, treatments and were they successful?)

13. How often are you having pain or discomfort?

- Less than once per week Several times per week Once a day
 Several times per day Most of the time

Personal & Family History

14. Have you ever been diagnosed with any of the following conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Irritable Bowl | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Other | | |

15. Please check the boxes which indicate conditions you have had or presently have. If any other conditions, please list them on the box down below:

- | | | |
|--|--|---|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Acne | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Amnesia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Colitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Migranes | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Parasites | <input type="checkbox"/> Pelvis Inflammatory Disease | <input type="checkbox"/> Peritonitis |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Post-Partum Depression |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Warts | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Worms | <input type="checkbox"/> Yellow Fever |
| <input type="checkbox"/> Other | | |

16. Personal Social Habits

	Yes	No
Smoke or use tobacco products		
Drink Alcohol		
Drink Caffeine		
Other, to be discussed		

17. Major current health complaints in order of importance to you:

	Complaint	Since when?	Causes
1			
2			