CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____

NAME YOU PREFER TO BE CALLED_____ SOCIAL SECURITY #_____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

MOBILE PHONE _____ MOBILE PHONE PROVIDER (for appt reminder) _____

AGE _____ BIRTH DATE _____ MARITAL STATUS: M S D W # OF CHILDREN _____

OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED ____

EMAIL ADDRESS: _____

NAME & ADDRESS OF YOUR FAMILY DOCTOR _____

HEALTH INFORMATION

PLEASE MARK THE SYMPTOMS OR CONDITION THAT YOU CURRENTLY HAVE?

- ☐ LEG CRAMPS
- ☐ FATIGUE/LOW ENERGY
- ☐ WEAK ARMS & LEGS
- ☐ HANDS & FEET COLD
- ☐ MENSTRUAL DIFFICULTIES
- ☐ PALPITATIONS
- ☐ DIZZINESS
- ☐ HEADACHE
- ☐ EARS RING
- ☐ SEE BLACK SPOTS
- ☐ IRRITABLE
- ☐ DEPRESSION
- ☐ NUMBNESS/TINGLING
- ☐ HEARTBURN/INDIGESTION
- ☐ INSOMNIA
- ☐ ANXIETY
- ☐ ALLERGIES
- ☐ ARTHRITIS
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER
- ☐ LOW APPETITE
- ☐ ABDOMINAL BLOATING
- ☐ PERSPIRE EASILY
- ☐ NIGHT SWEAT
- ☐ CONSTIPATE
- ☐ DIARRHEA

WHAT IS YOUR MAJOR COMPLAINT?_____

DATE OF SYMPTOMS FIRST APPEAR _____ SAME CONDITION IN THE PAST? ☐ YES ☐ NO

DOCTORS OR HOSPITALS WHO HAVE TREATED THIS CONDITION _____

WHAT SURGERIES HAVE YOU HAD? _____ YEAR? _____

OTHER HEALTH PROBLEMS NOT LISTED ABOVE _____

CURRENT MEDS: ☐ PAIN KILLERS ☐ MUSCLE RELAXERS ☐ NONE ☐ OTHERS _____

FEMALE PATIENTS ONLY: PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD? _____

PAYMENT INFORMATION

METHODS: ☐ HEALTH INSURANCE ☐ AUTO INSURANCE ☐ CREDIT CARD ☐ CASH ☐ CHECK ☐ OTHER

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. A service charge of 2% or 24% APR will be added to all overdue accounts. I am also liable for all legal and collection fees.

PATIENT'S SIGNATURE _____ DATE _____