

New Client Information

Name: _____ Birthdate: _____ Today's date: _____

Address: _____
Street City State Zip Code

Telephone: (H) _____ (Cell) _____ E-mail _____

Marital Status: Single Married Divorced Separated Widowed Number of Children: _____

Occupation: _____ Referred by: _____

Major Complaints in order of importance to you

<u>Complaint</u>	<u>Since</u>	<u>Cause</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications are you currently taking?

<u>Medication</u>	<u>Dose</u>	<u>Since</u>	<u>Adverse Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What other treatment plans are you currently following?

<u>Treatment</u>	<u>Since</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which of the following conditions have you had? (please circle all that apply)

Abscesses	Cold sores	Genital herpes	Menstrual problems	Respiratory disease	Thyroid condition
Acne	Fatigue	Goiter	Miscarriage	Root canal	Tonsillitis
Alcoholism	Depression	Gout	Mononucleosis	Scarlet fever	Tropical disease
Allergies	Diabetes	Hay fever	Mood problems	Seizures	Tuberculosis
Anemia	Dizziness	Headaches	Mumps	Septicemia	Uterine fibroid
Asthma	Digestive problems	Heart disease	Parasites	Sexual abuse	Vaginitis
Athlete's foot	Ear infections	Hepatitis	Pelvic inflammatory disease	Sinusitis	Venereal warts
Back pain	Endometriosis	Infertility	Pleurisy	Skin disease	Vertigo
Cancer	Fibromyalgia	Ingrown toenails	Pneumonia	Sties	Warts
Canker sores	Flu	Joint pain	Psoriasis	Stroke	Whooping Cough
Chicken pox	Gallstones	Kidney Disease	TMJ disease	Sun stroke	Worms
Other?					

Have you had any infectious disease from which you have never fully recovered?

What operations have you had?

<u>Operation</u>	<u>When</u>	<u>Complications</u>
_____	_____	_____
_____	_____	_____

What major injuries have you had?

<u>Injury</u>	<u>When</u>	<u>Long term effects</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Age of first menses? _____ Number of pregnancies: _____ Miscarriage/abortion: _____

Any adverse effects from vaccinations? _____

Have you ever taken antibiotics for a prolonged period of time? _____

For what condition? _____

When was your last physical exam? _____

Have you lost any weight lately? _____ How many pounds? _____ What exercise do you do? _____

How frequently do you exercise? _____

How much of the following are you using: Tobacco _____

Coffee _____ Tea _____ Alcohol _____

Recreational drugs _____

Which of the following have affected your relatives?

(Please circle all that apply)

Alcoholism	Depression	Heart disease	Pneumonia
Allergies	Diabetes	High blood pressure	Skin disease
Arthritis	Epilepsy	Mental illness	Syphilis
Asthma	Gonorrhea	Paralysis	Tuberculosis
Cancer	Gout		

<u>Relative</u>	<u>Age if alive</u>	<u>Age at death</u>	<u>Ailments</u>
Mother	_____	_____	_____
Father	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Are you currently under the care of another health professional?

<u>Specialty</u>	<u>For what condition(s)</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the date of your last blood work _____

If there is anything specific you would like to share/add, please do so below!
