Client Information Date:

Full Name:	Sex: M F
Home or Mailing Address:	
Home Phone: Work Phone: Email:	
Emergency Contact: Phone:	
Date of Birth: Age: Place of Birth:	
Occupation: How Long:	
Referred by:	

Health Care Information

Primary Care Physician:	
Address:	
Phone:	Fax:

Please mark or list other therapies you are involved in and the practitioner.

- ❑ *Acupuncture:*
- ❑ *Chiropractic:*
- ❑ *Healing Touch:*
- ❑ *Fitness Programs:*
- ❑ *Massage Therapy:*
- ❑ *Osteopathy:*
- ❑ *Psychotherapy/Psychiatry/Counseling:*
- ❑ *Spiritual Counseling:*
- ❑ *Yoga:*

Insurance Information:

Is this visit covered by Insurance (Cigna, MDIPA, United Healthcare) YES NO

*If **No**, skip this section*

Insurance company (if applicable)
Phone Number for Claims:
Claims Address:
Policy/Group number:
Individual ID number:
Co-pay amount (if applicable):

What is your primary reason for this visit?

____

____

____

Family History

Father Alive Deceased

Mother Alive Deceased

Brothers # Alive Current Health #Deceased Cause of Death

Sisters # Alive Current Health #Deceased Cause of Death

Children #Alive Current Health #Deceased Cause of Death

Check any illnesses that have occurred in any blood relatives:

Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis Obesity Heart Disease
High Blood Pressure Nervous Illness Allergy Alcoholism Mental Illness Stroke Other:

Personal Medical History

How would you describe your health as a child?

Check any illnesses or conditions you have or had in the past:

Diabetes Glaucoma Heart Trouble High Blood Pressure STD Alcoholism Cancer Asthma Anxiety
Bleeding Tendencies Tuberculosis Mumps Pneumonia Allergies Heart Attack Rheumatic Fever
Measles Chicken Pox Meningitis HIV Multiple Sclerosis Mononucleosis High Fevers Antibiotic Uses
Hepatitis Fibromyalgia Chronic Fatigue Auto Immune Disease Mental Illness Eating Disorder
Sinusitis Irritable Bowel Kidney Stones Crohn's Ulcerative Colitis High Cholesterol High Triglycerides
Stroke Thyroid Disease Other (describe)

Have you ever travelled outside the United States? Yes______ No_______
Is so, when and where?____

List illnesses which you were hospitalized or any surgeries you have had:

Height: Dressed weight: How long at this weight: Ideal weight:

Current medications:

Vitamins/Minerals/Herbs:

Food allergies:
Have you had allergies or sensitivities to any medicines or other substances? Yes No
If yes please list:

Lab Work:
Total Cholesterol HDL: LDL Triglycerides:
Blood Sugar: Hemoglobin A1C:
Other:

1. Are you on a special diet? Yes____ No____
   _____ ovo-lacto _____ vegetarian _____ other (describe):
   _____ diabetic _____ vegan ___________________________
   _____ dairy restricted _____ blood type diet ___________________________

2. Is there anything special about your diet that we should know? Yes____ No____
   If yes, please explain: ____

3. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?
   Yes____ No____
   b. If yes, are these symptoms associated with any particular food or supplement(s)?
   Yes____ No____
   c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
   ____
   ____

4. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

5. Do you feel much **worse** when you eat a lot of :
   ________high fat foods ________refined sugar (junk food)
   ________high protein foods ________fried foods
   ________high carbohydrate foods ________1 or 2 alcoholic drinks
   (breads, pastas, potatoes) ________other ______________________________

6. Do you feel much **better** when you eat a lot of :
   ________high fat foods ________refined sugar (junk food)
   ________high protein foods ________fried foods
   ________high carbohydrate foods ________1 or 2 alcoholic drinks
   (breads, pastas, potatoes) ________other ______________________________

7. Does skipping a meal greatly affect your symptoms? Yes____ No____

8. Have you ever had a food that you craved or really "binged" on over a period of time?
   Food craving may be an indicator that you may be allergic to that food. Yes____ No____
   If yes, what food(s)? ____
   ____

9. Do you have an aversion to certain foods? Yes____ No____
   If yes, what foods? ____

10. As a child, were there any foods that you had to avoid because they gave you symptoms?
    Yes____ No____
    If yes, please: name the food and symptom (Example: milk – gas and diarrhea) _________________________

11. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

12. Intestinal gas: ________Daily ______ Present with pain
________Occasionally ______ Foul smelling
________Excessive ______ Little odor

13. a. Have you ever used alcohol? Yes____ No____
b. If yes, how often do you now drink alcohol?
___ No longer drinking alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week
c. Have you ever had a problem with alcohol? Yes____ No____
If yes, please indicate time period (month/year): from ________ to ___________.

14. Have you ever used recreational drugs? Yes____ No____

15. Have you ever used tobacco? Yes____ No____
If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
_____Cigar _____Pipe _____Patch/Gum

16. Are you exposed to second hand smoke regularly? Yes____ No____

17. Do you have mercury amalgam fillings? Yes____ No____

18. Do you have any artificial joints or implants? Yes____ No____

19. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? ________spring ________fall
________summer ________winter

20. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
If yes, which one(s)? _lead ______________________cadmium
________arsenic ________mercury

________aluminum

21. Do odors affect you? Yes____ No____

22. Have you ever had psychotherapy or counseling? Yes____ No____
    Currently? _____ Previously? _____ If previously, from ______ to _______.
    What kind? ____

23. Do you exercise regularly? Yes____ No____

    If so, how many times a week?
    1.______1x
    2.______2x
    3.______3x
    4.______4x or more

    When you exercise, how long is each session?
    1.______ ≤15 min
    2.______ 16-30 min
    3.______ 31-45 min
    4.______ > 45 min

    What type of exercise is it?
    ________jogging/walking
    ________basketball
    ________home aerobics
    ________tennis
    ________water sports
    ________other ______________________________

Payment and Cancellation Agreement:

I understand that payment is expected at the time of my visit and agree to make full payment that the time of my visit unless other arrangements have been made, such as payment by insurance.

I understand that when I schedule an appointment for myself that I am agreeing to pay for that set aside time. I agree to provide this office with at least 24 hours notice when canceling an appointment. I understand that if I cancel an appointment without giving 24 hours notice I may be required to pay a charge up the cost of the appointment for the time I had reserved.

Patient Signature: ____Date: ______________