CONFIDENTIAL PATIENT INFORMATION

1. Rate the intensity/severity of your problem on a scale of 1 to 10 (10 being the worst):_____
2. When did your condition begin and how? _____
   _____
3. Have you ever had this condition before? No □ Yes □ please explain
   _____
   _____
4. How often does this condition bother you? _____constantly _____x/day _____x/week
5. Have you seen **ANY** other doctors for this condition? Please **LIST** their name, location and what services they performed?
   _____
   _____
   _____
6. Have you missed any work as a result of your condition? Starting? _____ If yes, how much? _____
   _____
7. Has this condition interfered with any of the following? No □ Yes □ - please circle all that apply
   sleep immune system job appetite energy level
8. Have you noticed any changes in your functional habits? No □ Yes □ - please circle all that apply
   appetite bowel movements urination menstrual cycle
   other _____
9. List **ALL** the prescriptions, over the counter medications and nutritional/herbal supplements you are taking:
   _____
   _____
   _____
10. List **ALL** the surgical procedures you have **ever** had, if you have **ever** been hospitalized and what for, and any motor vehicle accidents **ever**:
    _____
    _____
    _____
11. What is your height and weight? _____
12. Please **LIST** which family members have: Cancer □ Arthritis □ Rheumatoid arthritis □ Stroke □ Down's syndrome □ Prostate problems □ Other □
    _____
    _____
13. **Females** -Are you pregnant? No □ - Yes □ due date _____ Last Menstrual Period_____

Patient Signature: _____ Date: _____/_____/_____
(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature:_____ Date: _____/_____/_____

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