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:______/______ /______