

NEW PATIENT INFORMATION

Check Any Of The Following That May Apply To You

Health Issues:

- | | | | |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleeplessness |
| <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> AIDS or ARC | <input type="checkbox"/> Heart | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent Illnesses | <input type="checkbox"/> Allergies | <input type="checkbox"/> Genetic Disorders |
| <input type="checkbox"/> High Stress | <input type="checkbox"/> Poor Diet | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Over Weight |
| <input type="checkbox"/> Under Weight | <input type="checkbox"/> Lungs | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disorders |
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Infections | <input type="checkbox"/> Other _____ | |

If Female, is there any possibility that you are pregnant? Yes No

Intake Or Use:

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Pain Relievers | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Other: _____ | |

Check Any Problems That You May Have Had Within The Last Six Months

Muscles-Skeleton

- Low Back Pain
- Middle Back
- Neck
- Hips / Legs
- Joint Pain
- Shoulders/Arms

Circulation-Breathing

- Chest Pain
- Lungs/Breathing
- Blood Pressure
- Heart Rate
- Poor Circulation
- Coughing or Wheezing

Eye-Ear-Nose-Throat

- Eyes / Vision
- Dental / TMJ
- Throat / Voice
- Ears / Hearing
- Sinus Pain / Drainage

Nerve System

- Headaches
- Nervousness
- Numbness
- Weak Muscles
- Dizziness
- Forgetfulness
- Depression
- Fainting
- Seizures
- Cold Hands / Feet
- Stress Reactions
- Shaking / Tremors

Digestion-Elimination

- Poor Appetite
- Excessive Thirst
- Nausea
- Diarrhea
- Constipation
- Hemorrhoids
- Weight Loss / Gain
- Heartburn
- Change In Stools

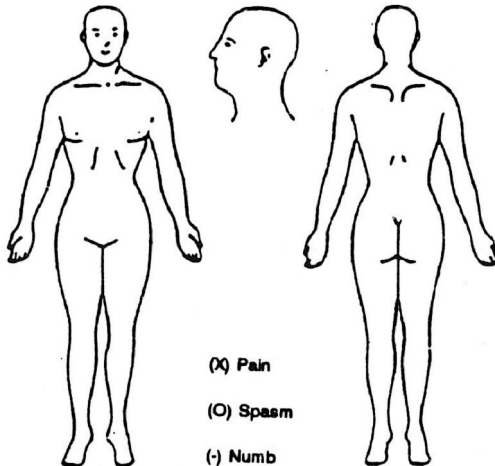
Urinary-Genitals

- Pain With Urination
- Infrequent Urination
- Frequent Urination
- Weak Stream
- Bladder Control
- Genitals

Female Only

- | | |
|--|--|
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Breast Lumps/Pain |
| <input type="checkbox"/> Back Pain w/ Period | <input type="checkbox"/> Breast Implants |

Please Mark Area Of Concern & Sign



I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge

Patient's Signature: