NEW PATIENT QUESTIONNAIRE

Name____________________________________Today's Date__________________

Address____

City___________________________ State__________ Zip_____________________

Phone_________________ Email ____

Occupation________________ Birthdate ___/____/___ Referred by_______________

Describe any aches, pains, concerns, or difficulties you are currently experiencing:

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Date the symptoms first appeared _______________

If there is a known cause, please describe: __________________________________

____

Have you ever had this condition before? Y / N If yes, when?__________________

Are you currently getting any treatment for any health conditions? Y / N

If yes, please explain: ____

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Are you currently taking any medications? Y / N

If so, please list: ____

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Have you had any major illnesses, surgeries, or hospitalizations? Y / N

If so, please explain: ____

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Please mark/highlight/circle any Current (C), Recurrent (R), or Previous (P) Conditions

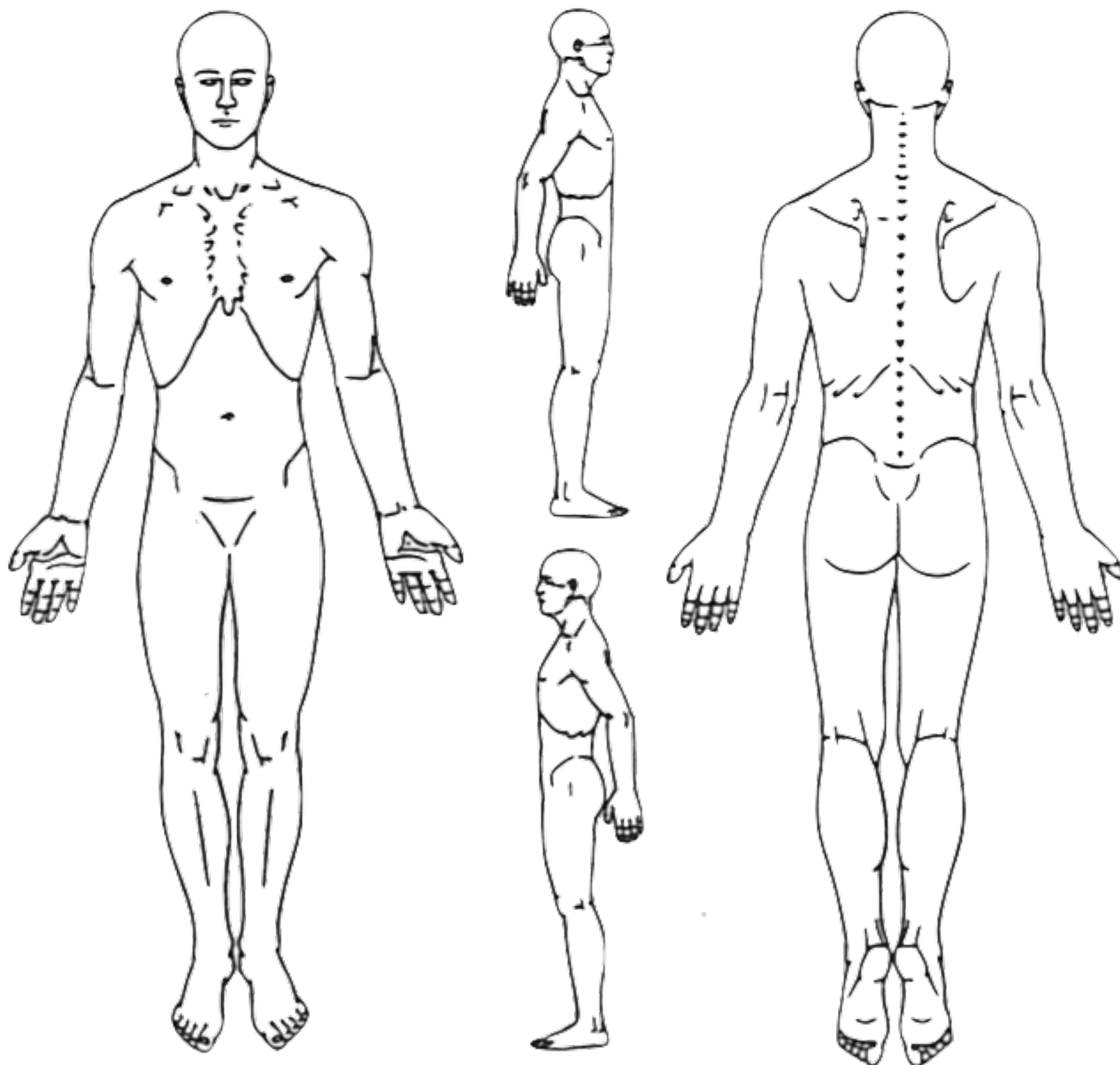
Fatigue Fevers / Sweats / Chills Fainting / Dizziness Depression Anxiety Mood swings Weight changes Allergies Swelling Lumps / cysts / tumors Enlarged lymph nodes Cognition decline	Cough Breathing difficulty Asthma Reactive Airway Chemical exposure Chemical sensitivity Frequent Colds	Difficult digestion Nausea / Vomiting Ulcers / Colitis Inflammatory problems Elimination problems Abdominal cramping Thyroid problem Liver trouble Gall bladder trouble Hernia Food allergies Heartburn
Headaches Vision problems Eye pain / pressure Earache / drainage / sounds Hearing loss Sinus trouble Dental problems Balance problems Vertigo Concussion Brain Injury Seizures	Blood Pressure problems Heart problems Chest ache or pain Palpitations Previous Heart Attack Swelling of legs or ankles Poor circulation Varicose Veins History of Stroke Clotting disorder Cholesterol problem History of Blood Clot	Urinary problems Urinary leaking Bladder / Kidney infections Kidney Stones Urogenital infections Menstrual problems/pain/cramping Prostate problems Painful intercourse Menopausal symptoms Hysterectomy Currently pregnant
Skin eruptions Itching Bruise easily Eczema Sensitive skin Lumps / bumps Poor wound healing Skin changes	Back pain / stiffness Neck pain / stiffness Jaw pain / TMJ Painful tailbone Knee / ankle / foot trouble Shoulder trouble Wrist / hand / thumb pain Hip joint or Knee pain Sciatica Bursitis Arthritis Nerve pain / numbness / tingling Fracture(s) Osteoporosis / Osteopenia	Autoimmune disease Fibromyalgia Pain syndromes History of trauma Childhood abuse Diabetes Cancer Shingles Rheumatic disease Gout Tobacco Marijuana Alcohol Other substances

Please indicate anything I may have missed ______________________________________

Mark and "x" on the scale below for each item:

	none	a little	some	a lot	great
Stress					
Happiness					
Sleep					
Nutritious Diet					
Exercise					

Please circle the areas of concern on the diagrams below:



Terms

Please arrive on time to receive full benefit of the time scheduled for our treatment. If you need to change an appointment time, please let me know with as much notice as possible. 24 hours notice for cancellation is required or the fee for the session is still charged. I do not make pre-appointment reminder calls. Payment is expected at the time of the visit.

Signature____

Date ________________________