

Patient Information/History Form

Name: _____ D.O.B: _____ Age: _____

Mailing Address: _____

Home Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Occupation: _____

In case of Emergency Contact: _____ Tel: _____

Health History

Chief Complaint: _____

Physicians Name: _____ Date of Last Exam: _____

Have you ever been hospitalized? Yes No If yes, what for? _____

Which of the following conditions are you currently being treated or have been treated for in the past:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Heart disease / Murmur / Angina | <input type="checkbox"/> Shortness of breathe | <input type="checkbox"/> Eye disorder / Glaucoma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney / Bladder problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems / cough | <input type="checkbox"/> Liver problems / Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heartburn (reflux) | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia or blood problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Ulcers/colitis |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tonsillitis |

Please describe any current or past medical treatment not listed above

Please list your past surgeries

Allergies (Please list): _____

Medications / Supplements (Please list):

Social and Preventive History

Do you currently smoke or chew tobacco? Yes No
How many packs per day? _____

If no, have you in the past? Yes No

Do you drink alcohol, beer, or wine? Yes No
How many drinks per week? _____

If no, have you in the past? Yes No

Do you currently drink coffee and/or tea? Yes No
If yes, how many cups per day? _____

Do you exercise daily/weekly? Yes No
If yes, what type of exercise? _____

CANCELLATION POLICY:

Office visit is by appointment only. If you must cancel or change an appointment, please allow 24 hours' notice so the time may be used to help another person. In the event that 24 hours' notice isn't given, a cancellation fee of \$100 will be applied to your credit card. The charge is payable immediately and additional appointments will require advanced payment.

Card #: _____ Expiry: _____ CVD: _____ (3 digits)

PAYMENT POLICY:

Kindly note the time slot doesn't necessarily reflect the amount of time a treatment takes. Your specific treatment may take longer or shorter than the specified time slot. *Each treatment is specific to the patient.* Full payment is due at the time services are rendered.

Initial consultation:	\$140
Follow-up consultation:	\$100

EMAIL CONTACT POLICY:

Please check if you do not want contact via email regarding appointments, openings, workshops, lectures, etc:

My preferred method of contact: email phone

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate. I have read and understood the Cancellation, Contact and Payment Policies:

Patient/Legal Guardian Signature: _____ Date: _____