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:

☐Heart disease / Murmur / Angina	☐Shortness of breathe	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Kidney / Bladder problems	☐Seizures
☐High blood pressure	☐Lung problems / cough	☐Liver problems / Hepatitis	☐Stroke
☐Low blood pressure	☐Sinus problems	☐Headaches / Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems	☐Cancer
☐Anemia or blood problems	☐Thyroid problems	☐Depression / Anxiety	☐Ulcers/colitis
☐Swollen ankles	☐Ear problems	☐Psychiatric care	☐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:	**$150**
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. I also consent to membership in a Private Practice:

Patient/Legal Guardian Signature: _____ Date: _____