PLEASE PRINT CLEARLY

Full Name:_________________________________Best Phone#:______________________

Email:______________________________________May we contact you via email? Y N

Address::______________________________________City:__________________________

State::______ZIP:__________Occupation:_________________________DOB:__________

Place of Birth:___________________________Ethinicity:_________________________

Gender or Preferred Gender Pronoun:_____________

Partner Status: Single Married Divorced Widow In Relationship

Emergency Contact:____________________________Phone #____________________

Primary Doctor:____

How did you hear about us?____

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding/Clotting disorder
- ❑ Fainting disorder
- ❑ Believe you may be OR are pregnant
- ❑ HIV
- ❑ Hepatitis B/C

Primary Complaint	Does this affect daily activities?	What makes it better?
	YES NO	HEAT COLD REST EXERCISE
Secondary Complaint	-------------	------------
	YES NO	HEAT COLD REST EXERCISE

Have you seen an M.D. for these conditions? YES NO

List all medications, supplements, herbs, and vitamins you are currently taking:

Are you allergic to any substance, food or drug? Y N   Please list:

PAST MEDICAL HISTORY

□ Accidents or injuries	□ Allergies	□ Asthma	□ Cancer
□ Diabetes	□ Heart Attack	□ High Blood Pressure	□ Hepatitis
□ Epilepsy	□ Stroke	□ Surgeries	□ STD
□ Kidney Disease	□ Liver Disease	□ Tuberculosis	
□ History of physical/emotional/sexual abuse		□ Childhood Illnesses:	

Height _________ Current Weight ________lb. Max Weight ________lb. When? ______

Have you ever been on a restricted diet? Y N   What kind?______________________

Do you have enough energy for the day? YES   NO   SOMETIMES

Do you have problems (circle any) falling/staying asleep?   YES   NO

Do you have any digestive problems (bloating, constipation, etc.)?

How is your libido/sex drive?   LOW   NORMAL   HIGH

Does your body tend to be hot or cold?   HOT   COLD   NORMAL

Do you smoke?   YES NO   How many packs a day?____________________

How much coffee, tea, or cola do you drink a week?_______________________

How much alcohol do you drink a week?_______________________________

How often do you exercise per week? _________________________________

Job stresses:___________________Home stresses:______________________