Patient Information

First Name	Middle Initial	Last Name
Date of Birth *(mm/dd/yyyy)*	Preferred Name or Nickname	

Contact Information

Email Address	
Please check this box if you DO NOT wish to receive important reminders, announcements, etc. via your email	☐

Home Phone	Cell Phone	Work Phone

Street Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip

Emergency Contacts

Name	Relation	Phone Number
Name	Relation	Phone Number

Reasons for Your Visit (please circle as many as apply)

Abdominal / digestive issues	Allergies	Annual physical exam
Asthma / other breathing concerns	Blood pressure concerns	Diabetes
Dizziness	Ear / Nose / Throat / Sinus issues	Fatigue
Feminine Concerns	Headache	Hormone Questions
Skin problems	Thyroid concerns	
Chronic Pain (please specify location):		
Mood Problems (please specify):		
Other (please specify):		

Questions and Comments - Your main concerns for this visit

#1:
#2:
#3:

PLEASE CONTINUE ON REVERSE

Additional Medical Information

Any Known Allergies:

Current Medications / Supplementation (including dosages, if known):

Ongoing Medical Conditions:

Past Surgical History:

Which specialists (if any) have you seen previously? (please circle all that apply)

Acupuncturist	Allergist	Cardiologist
Chiropractor	Dermatologist	Massage Therapist
Mental Health Professional	Nephrologist	OB/GYN
Plastic Surgeon	Other (please specify):	

How did you hear about us (Google, Facebook, etc.)?

If referred, by whom?

May we thank them?	YES	NO