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NAME _____ DATE _____

ADDRESS _____ ZIP _____

DATE OF BIRTH_____

PHONE (H)_____ (C)_____ (W) _____

E-MAIL _____ REFERRED BY _____

EMERGENCY CONTACT NAME _____ PHONE_____

PRIMARY CARE PHYSICIAN _____ PHONE _____

Please list your 3 primary health concerns in priority order (Ex: allergies, weight problems, fatigue, hormone imbalance, digestion, frequent colds, prevention of illness, osteoporosis, prostate, fibromyalgia, chronic fatigue syndrome, poor health)

Health Concern	**Prior Treatment/Approach**
1.	
2.	
3.	

Additional concerns:

_____

_____

List any supplements you are taking or have taken along with the dosage and dates taken.

Supplement	**Brand**	**Dosage**	**Date**
1.			
2.			
3.			
4.			
5.			

List any medications you are taking or have taken along with the dosage and the dates taken.

Medication	**Dosage**	**Date**
1.		
2.		
3.		
4.		
5.		

List any past and current diagnoses and the date diagnosed.

Diagnosis	**Date Diagnosed**	**Active**	**Resolved**
1.			
2.			
3.			

Do you follow or have you followed any specific nutrition, diet, or exercise programs and how well did they work for you? Ex: Atkins, Zone, Weight Watchers, Curves, Golds Gym, etc.

Program	**Results/Outcome**	**Date Started**	**Current**	**Discontinued**
1.				
2.				
3.				

Do you exercise regularly? If yes, what technique and frequency? Ex: Aerobics 3x/week

_____

_____

CONGRATULATIONS !! YOU HAVE TAKEN A MAJOR STEP TOWARD IMPROVING YOUR HEALTH AND INCREASING YOUR QUALITY OF LIFE!!

BETTER HEALTH THROUGH CHIROPRACTIC AND CLINICAL NUTRITION