NATURAL HEALTH
PATIENT INFORMATION FORM

Please print clearly:

Name_____Date_____

Address_____

City _____ State_____ ZIP_____

Best Phone # (____) ____-_____ E-mail address: _____

Occupation: _____Employer: _____

Length of time at present occupation_____ Social Security #_____

Date of Birth _____ Age _____ Sex: M/F Height _____ Weight _____

REFERRED BY_____(We would like to thank the person who referred you)

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

What brings you in the office today?

_____

_____

When did this issue start? _____

What do you think caused these problems?

_____

What have you tried to correct this _____

_____

Are things: ___Better ____Worse ____Same

Is this affecting: ____Home life ____Work life ___Hobbies ___Sleep

If yes, please explain: _____

Is this due to: Work_____ Auto_____ Other_____

Other Medical Conditions or problems_____

_____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

_____

PAST HISTORY:

List any major illnesses, with approximate dates: _____

_____

List any surgery or operations, with approximate date: _____

_____

Past Accidents or injuries, with approximate date: _____

_____

Have you been to a chiropractor before, name of Dr. and date: _____

Current Medications:_____

_____

_____

Over the Counter or Nutrition: _____

List any known drug allergies you have: If no allergies known check here_____

_____

Have you had an X-ray or CT scan or MRI on your low back spine in the last 28 days? ____Yes ____No

FAMILY HISTORY:

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Children	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply):

Father: Cancer / Diabetes / Heart / Other_____ Sister: Cancer / Diabetes / Heart / Other_____

Mother: Cancer / Diabetes / Heart / Other_____ Brother: Cancer / Diabetes / Heart / Other_____

Other family members _____: Cancer / Diabetes / Heart / Other_____

For Chiropractic Treatment

INSURANCE: (Give card to receptionist so she can make a copy)

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Natural Health. I authorize Natural Health to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payments of benefits. I understand that I am responsible for all cost of chiropractic care regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by the Doctors, any fees for professional services will be immediately due and payable.

PATIENTS SIGNATURE:_____ DATE:_____

GUARDIAN'S SIGNATURE:_____ DATE:_____

SOCIAL HISTORY:

Do you exercise? _____ If Yes, how often and type of exercise_____

Describe you stress level:_____

Do you stretch or do yoga? ___ Yes ___ No

Do you eat a healthy diet? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No Do you drink soda, including diet soda? ___ Yes ___ No

Approximately, how many glasses of water do you drink per day? _____

Do you currently smoke tobacco of any kind? ____Yes ____Former smoker ____Never been a smoker

If yes, how often do you smoke: ____Current every day smoker ____Current sometimes smoker

If yes, how interested, Not Interested 0 1 2 3 4 5 6 7 8 9 10 Very Interested

There are six kinds of disturbances that can affect the human body. These are the following: GLANDULAR, ELIMINATIVE, NERVOUS, DIGESTIVE, MUSCULAR AND CIRCULATORY. All dis-eased conditions, aches & pains and other discomforts experienced by the body can be attributed to one or more of the above disturbances to the body's 6 systems or "ZONES". Please check all that apply below.

GLANDULAR

___ memory loss
___ emotions
___ skin
___ hair
___ low energy
___ throat
___ adrenals
___ sleep
___ male/female functions
___ hot temper
___ inability to concentrate

ELIMINATIVE

___ sinuses
___ nasal passages
___ throat
___ lungs
___ kidneys
___ lymphatics
___ bladder
___ intestines/colon

NERVOUS

___ eyes
___ ears
___ balance
___ sleep
___ solar plexus
___ digestion
___ unable to relax
___ tension
___ nervousness

DIGESTIVE

___ appetite
___ taste
___ reflux
___ liver
___ gallbladder
___ stomach
___ pancreas
___ intestines
___ weight gain

MUSCULAR

___ neck
___ shoulders
___ arms
___ upper back
___ middle back
___ lower back
___ chest
___ abdomen
___ weakness
___ lower extremities
___ feet

CIRCULATORY

___ thyroid
___ blood pressure
___ headaches
___ cold hands
___ cold feet

I, the undersigned, hereby give permission for care.

Thank you!

Patient's Signature _____ Date_____