New Patient Information

Name: ______________________________ Date: _______________

DOB: _____ / _____ / ________ Age: ________

Preferred Contact Number: (______) ______ - __________

Primary Email Address: ____

Mailing Address: __________________________________

__________________________________ Zip: __________

Occupation: __________________________________ For How Long: __________

If someone referred you here, please tell us know whom: ______________________________

Please describe what kind of trouble you're having, and the result you'd like to achieve:

____

How long have suffered from this problem? ____

What have you tried that hasn't worked so far? ____

On a scale of 1-10, how committed are you to solving this problem? _______________________

What it's at its worst, how does it make you feel? ______________________________________

Does it interfere with your work, family life, hobbies, or life? ___________________________

What makes this problem worse? ____

Does handling this problem cause stress for you? Yes: _____ No: _____

How much older does it make you feel? ____

What gives you temporary relief? ____

What's the pattern of this problem: *Constant:* ___ *Off/On:* ___ *Daily:* ___ *Weekly:* ___ *Monthly:* ___

What is the effect that it has, if any, on your other body functions: ______________________

Do you remember how it started? Yes: ____________________________________ No: _____

Have you ever been knocked unconscious? Yes: _____ No: _____

If you're on any type of medication, please list it here, including over-the-counter drugs:

____

In your opinion, how would you rate your level of health (1-10): ________

Do you have any other health goals/concerns? ____

Signature:

____

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