# Confidential Patient Information Sheet

Name: _____ Today's Date: _____

Email: _____ Phone: _____

□ Male □ Female □ Gender Nonconforming □ Transgender Preferred Pronouns: _____

Address: _____

Emergency Contact Name: _____ Phone: _____

Relationship to You: _____ Your Date of Birth: _____

Relationship Status: □ Single □ Married □ Partnered □ Polyamorous □ Divorced □ Widowed

Reason for Your Visit Today: _____

_____

Are you being treated for this condition by anyone else? □ Yes □ No Has this condition been diagnosed by a MD? □ Yes □ No If yes, diagnosis: _____

Drug or Supplement Name Date Started? Reason for Taking?

_____

_____

_____

_____

_____

Do you follow any particular diet or way of eating? _____

Physical activity? _____ Do you have enough energy? □ Yes □ No

Hospitalizations or Surgeries: _____

**Cardiovascular:**
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

**Emotional / Mental**:
- ☐ Mild Depression
- ☐ Clinical Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety

**Energy & Immunity**:
- ☐ Chronic Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections

**Respiratory**:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Tuberculosis
- ☐ Shortness of Breath

**Musculo-Skeletal:**
- ☐ Neck /Shoulder Pain
- ☐ Muscle Spasms
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

**Eye, Ear, Nose & Throat:**
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems

**Genito-Urinary Tract**:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence

**Neurological**
- ☐ Vertigo / Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy

**Gastrointestinal:**
- ☐ Stomach Ulcers
- ☐ GERD or Acid Reflux
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Bloating / Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Blood in Stool

**Endocrine**:
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes (Type I or II)
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

**Other:**
- ☐ Cancer (Type): _____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema
- ☐ Cold Hands or Feet

**Reproductive:**
- ☐ Impotence
- ☐ Prostate problems
- ☐ Testicular pain
- ☐ Painful intercourse
- ☐ Infertility
- ☐ Vaginal Discharge
- ☐ PMS
- ☐ Clotting
- ☐ Irregular cycles
- ☐ Heavy or Scanty flow
- ☐ Spotting

Average # Days between menstrual cycles: _____
Average # Days of flow: ___

Pregnancies: _____
Births: _____
Miscarriages: _____
Abortions: _____