

### Patient Profile

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Occupation: \_\_\_\_\_ Full or Part Time: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Referred by: \_\_\_\_\_

Next of kin (or emergency name): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

### CURRENT HEALTH CONDITION

When, where and from whom did you last receive medical or health care? \_\_\_\_\_  
\_\_\_\_\_

What are your most important health concerns?

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any contagious diseases at this time:  Yes  No

If yes, what? \_\_\_\_\_

### CURRENT MEDICATIONS

Do you take or use:

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Laxatives            | <input type="checkbox"/> Pain relievers      | <input type="checkbox"/> Antacids            | <input type="checkbox"/> Cortisone   |
| <input type="checkbox"/> Tranquilizers        | <input type="checkbox"/> Thyroid medication  | <input type="checkbox"/> Sleeping pills      | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Appetite supressants | <input type="checkbox"/> Nasal decongestants | <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Hormones    |

Please list any prescription or over-the-counter medications, vitamins or other supplements you are taking and dosages:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**GENERAL INFORMATION**

Weight: \_\_\_\_\_ lbs. Weight 1 year ago: \_\_\_\_\_ lbs.  
Maximum weight: \_\_\_\_\_ lbs. When: \_\_\_\_\_  
Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.  
When is your energy the best during the day? \_\_\_\_\_ Worst? \_\_\_\_\_

**CHILDHOOD ILLNESSES**

Rubella (German 3-day measles)  Measles (2 week)  Mumps  Chickenpox  
 Whooping cough  Rheumatic fever  Polio  Scarlet fever  
 Roseola  Asthma  Others \_\_\_\_\_

**IMMUNIZATIONS**

Pertussis  Tetanus  Polio  Diphtheria  
 Measles/Mumps/Rubella  Hepatitis  Others \_\_\_\_\_

**X-RAYS AND SPECIAL STUDIES**

Electrocardiogram (EKG)  Electroencephalogram (EEG)  Intravenous Pyelogram (IVP)

What x-rays, CAT scans, or other studies have you had? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITALIZATION AND SURGERY**

What hospitalizations or surgeries have you had? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Are you hypersensitive or allergic to:  
Any drugs: \_\_\_\_\_  
\_\_\_\_\_  
Any foods: \_\_\_\_\_  
\_\_\_\_\_  
Any chemicals or environmental toxins: \_\_\_\_\_  
\_\_\_\_\_  
What happens to you when you have an "allergy attack?" \_\_\_\_\_  
\_\_\_\_\_

What prior types of allergy testing have you had?  
 Intradermal  Scratch  Blood IgG food  Blood IgE inhalant/food  Electroacupuncture  
 Kinesiology  Cytotoxic  Food Intolerance  None