



# NEW CLIENT INFORMATION

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

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Nickname or preferred name: \_\_\_\_\_ Marital Status: S M D W Other \_\_\_\_\_

Home / Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer / School: \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Status: Full-time Part-time Seasonal Other

In case of an Emergency – Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? \_\_\_\_\_

## HEALTH INFORMATION

**HEALTH CONCERNS:** Please list your top health concerns or complaints that you would like to address (in order of priority):

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Are these concerns affecting your quality of life? (Please circle all applicable)

Work / School: Y N Recreation: Y N Sleep: Y N

Exercise / Sports: Y N Walking: Y N Sitting: Y N

Eating: Y N Intimate/Personal Life: Y N Other: \_\_\_\_\_ Y N

### **General Information:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent Weight Loss  / Gain ? Amount? \_\_\_\_\_ lbs

Reason / method for weight loss / gain: \_\_\_\_\_ Number of Bowel Movements per day \_\_\_\_\_

Difficulty falling asleep? Y N Difficulty staying asleep? Y N Tired after full night's sleep? Y N

Lightheaded / irritable when hungry? Y N Crave sugar / salt? Y N Fatigue after meals? Y N

Need coffee / sweets 3-4pm? Y N Do you eat Breakfast? Y N Do you eat snacks between meals? Y N

What time do you eat Breakfast? \_\_\_\_\_ Usual breakfast foods: \_\_\_\_\_

What time do you eat Lunch? \_\_\_\_\_ Usual lunch foods: \_\_\_\_\_

What time do you eat Dinner? \_\_\_\_\_ Usual dinner foods: \_\_\_\_\_

What times do you eat Snacks? \_\_\_\_\_ Usual snacks: \_\_\_\_\_

Do you have any dietary restrictions? Y N Please explain: (vegetarian, gluten / dairy intolerance, Kosher etc.) \_\_\_\_\_

\_\_\_\_\_

Have you or do you consult with, or are you under the care of any of the following providers? (check all that apply)

- |                                            |                                           |                                             |                                    |
|--------------------------------------------|-------------------------------------------|---------------------------------------------|------------------------------------|
| <input type="checkbox"/> Medical Physician | <input type="checkbox"/> Naturopath       | <input type="checkbox"/> Acupuncturist      | <input type="checkbox"/> Homeopath |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Psychotherapist  | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Dentist   |
| <input type="checkbox"/> Nutritionist      | <input type="checkbox"/> Personal Trainer | <input type="checkbox"/> Other: _____       |                                    |

Comments (conditions, treatments, success, etc.) \_\_\_\_\_

**MEDICAL HISTORY:** – Please check all that apply (P = Past / C = Current):

- | P / C                                        | P / C                                         | P / C                                             | P / C                                     | P / C                                         |
|----------------------------------------------|-----------------------------------------------|---------------------------------------------------|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Abdominal Pains     | <input type="checkbox"/> Elbow/Hand Pain      | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Sweating             |
| <input type="checkbox"/> Ankle/Foot Pain     | <input type="checkbox"/> Excessive Thirst     | <input type="checkbox"/> Hip Pain                 | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Swollen Ankles       |
| <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Eye Pain             | <input type="checkbox"/> Insomnia                 | <input type="checkbox"/> Poor Appetite    | <input type="checkbox"/> Swollen Joints       |
| <input type="checkbox"/> Chest Pressure      | <input type="checkbox"/> Facial Pain          | <input type="checkbox"/> Irritability             | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Teeth Grinding       |
| <input type="checkbox"/> Clammy Hands        | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Joint Stiffness          | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Tingling in Feet     |
| <input type="checkbox"/> Confusion           | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Knee Pain                | <input type="checkbox"/> Shakiness        | <input type="checkbox"/> Tingling in Hands    |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Feel Loss of Control | <input type="checkbox"/> Low Back Pain            | <input type="checkbox"/> Shoulder Pain    | <input type="checkbox"/> Urination Difficulty |
| <input type="checkbox"/> Convulsions         | <input type="checkbox"/> Forgetfulness        | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Sinusitis        | <input type="checkbox"/> Walking Problems     |
| <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Lump in Throat           | <input type="checkbox"/> Slow Heart Rate  | <input type="checkbox"/> Weak Muscles         |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Fullness of Bladder  | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Sore Muscles     | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Dry Mouth           | <input type="checkbox"/> Headache             | <input type="checkbox"/> Nausea/Vomiting          | <input type="checkbox"/> Sore Throat      | <input type="checkbox"/>                      |
| <input type="checkbox"/> Earache             | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Neck Pain                | <input type="checkbox"/> Swallowing Pain  | <input type="checkbox"/>                      |

**Women only:** Is there any chance you might be pregnant? Y/N Date of last menstrual cycle: \_\_\_\_\_

Are you experiencing perimenopause? Y/N Reached Menopause Y/N Are you experiencing symptoms? Y/N

Do you currently, or have you used any of the following? (please circle all that apply) Birth Control Pills, Hormone Replacement

Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive

Length of use of each type ? \_\_\_\_\_ Have you ever had an abnormal PAP? Y/N

Age of menarche (periods began): \_\_\_\_\_ Age of children (if any): \_\_\_\_\_

# of pregnancies: \_\_\_\_\_ # of birth children: \_\_\_\_\_ # of C-Sections: \_\_\_\_\_

**HEALTH & FAMILY HISTORY:**

Identify any conditions that **you**, or any of **your family members** have now or have had in the past:

(X = Self, G = Grandparents, M = Mother, F = Father, S = Siblings)

- |                          |                      |                         |              |
|--------------------------|----------------------|-------------------------|--------------|
| ___ Alcoholism           | ___ Diabetes         | ___ Hepatitis A/B/C     | ___ Stroke   |
| ___ Anemia               | ___ Eczema/Psoriasis | ___ Herpes              | ___ Tumor(s) |
| ___ Cancer               | ___ Epilepsy         | ___ High Blood Pressure | ___ Ulcer(s) |
| ___ Cold sores           | ___ Goiter           | ___ HIV/AIDS            | Other: _____ |
| ___ Deep vein thrombosis | ___ Gout             | ___ Pleurisy            | _____        |
| ___ Depression/Anxiety   | ___ Heart disease    | ___ Pneumonia           | _____        |

Do you wear corrective lenses? Y N Date of last check-up / prescription change? \_\_\_\_\_

Date of most recent physical or annual exam: \_\_\_\_\_ Did you have blood-work done? Y N

Results / Concerns \_\_\_\_\_

Physical, chemical, structural and emotional stresses, common to our contemporary lifestyles, can result in dysfunction of the areas surrounding and involving the nervous system (the body's primary system which co-ordinates health}. The following may be seemingly insignificant events, however they may be contributing to your experiences of health and wellbeing today. Please feel free to add anything not listed here, and to ask any questions you may have regarding this section.

**ACCIDENTS:** Have you been involved in any of the following types of accidents? (check all that apply)

- Automobile     Motorcycle     Bicycle     Sports     Playground     Abuse     Other

Year (approximate)	Please describe (injuries, treatment, outcome)

**INJURIES:** Have you ever injured any of the following regions? (check all that apply)

- Head     Neck     Rib/Chest     Back     Pelvis/Hip     Arm/Hand     Leg/Foot

Year (approximate)	Please describe (injuries, treatment, outcome)

**SERIOUS ILLNESSES / HOSPITALIZATIONS / SURGERIES:** Please detail hospitalizations / serious illnesses / surgeries

Year (approximate)	Reason	Outcome

**MEDICATIONS:** Please list all medications you are currently or have recently taken (prescribed or over-the-counter)

Medication Name	Condition	Date Started	Prescribed By?

**NUTRITIONAL SUPPLEMENTS:** Please list all Vitamins and Nutritional Supplements you are currently or have recently taken

Supplement	Brand & Amount Consumed	Date Started	Prescribed by? (if applicable)

**PREVIOUS MEDICATION HISTORY:** Please list an approximate number of times you have taken antibiotics for illnesses, yeast infections, skin disorders (including acne), dental procedures, surgery etc. \_\_\_\_\_ Have you ever been on a long term antibiotic (1 month or more) or Intravenous (IV) ? Y N Have you ever taken probiotics? Y N

**ALLERGIES / SENSITIVITIES:** Please check and list all allergies / sensitivities

**Food:** Gluten Dairy Soy Nuts Other \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Seasonal/Latex/Other:** \_\_\_\_\_

**HABITS:** Please include current and previous amounts

	Daily	Weekly	Monthly	Never		5-7x/wk	3-5x/wk	1-3x/wk	None	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Exercise</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>8+ hrs</b>	<b>7-8 hrs</b>	<b>6-7 hrs</b>	<b>5-6 hrs</b>	<b>&lt;5 hrs</b>
Soda/Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Sleep</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>5+</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Rec. Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Meals / day</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If you no longer consume the above, please note length of consumption and date stopped.</i>						<b>8+ cups</b>	<b>4-7 cups</b>	<b>2-4 cups</b>	<b>&lt;8 oz</b>	
					<b>Water / day</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**WORK ACTIVITY:**  Heavy Labor  Light Labor  Mostly Sitting  Mostly Standing  Walking/Moving  Driving

**STRESS LEVEL:**  Very High  High  Medium  Low

Have you traveled in the last twelve months?  Y  N If yes: Where (especially internationally), \_\_\_\_\_

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Jacqui at any time.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Participant Name (Printed) Participant Signature Date

Parent and/or Guardian Printed Parent and/or Guardian Signature