



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: _____

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 check all applicable)

Work / School:	<input type="checkbox"/> Y <input type="checkbox"/> N	Recreation:	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep:	<input type="checkbox"/> Y <input type="checkbox"/> N	Exercise / Sports:	<input type="checkbox"/> Y <input type="checkbox"/> N
Eating:	<input type="checkbox"/> Y <input type="checkbox"/> N	Walking:	<input type="checkbox"/> Y <input type="checkbox"/> N	Sitting:	<input type="checkbox"/> Y <input type="checkbox"/> N	Intimate/Personal Life:	<input type="checkbox"/> Y <input type="checkbox"/> 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 3-5pm? Y N Do you eat Breakfast? Y N Do you eat snacks? 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: _____

List the three healthiest foods you eat during the average week: _____

List the three worst foods you eat during the average week: _____

Do you have any dietary restrictions? Y N Please explain: (vegetarian, gluten / dairy intolerance, Kosher 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"/> Unusual lumps
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Urination Difficulty
<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"/> Walking Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fullness of Bladder	<input type="checkbox"/> Menstrual Irregularities	<input type="checkbox"/> Sore Muscles	<input type="checkbox"/> Weak Muscles
<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Earache	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Swallowing Pain	

Are you currently under the care of any other provider(s)? (MD, Dentist, psychologist, please list condition or general care etc) _____

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 (if any): _____ # of C-Sections (if any): _____

HEALTH & FAMILY HISTORY:

Mark an X for any conditions that **you**, or any of **your family members** have now or have had in the past:

	Self	Mother	Father	Sibling(s)	Paternal Grandparent	Maternal Grandparent
Alcoholism						
Anemia						
Cancer						
Cold sores						
Deep vein thrombosis						
Depression/Anxiety						
Diabetes						
Eczema/Psoriasis						
Epilepsy						
Goiter						
Gout						
Heart disease						
Hepatitis A/B/C						
Herpes						
High Blood Pressure						
HIV/AIDS						
Pleurisy						
Pneumonia						
Stroke						
Tumor(s)						
Ulcer(s)						
Other:						

NATIONALITY: Some health issues can be related to our familial nationality or heritage. Please list your family heritage below:

Mother's Family _____ Father's Family _____

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 _____

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)**

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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)**

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

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

Year (approximate) **Reason** **Outcome**

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?**

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)**

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: _____

Have you have taken oral steroids (Cortisone, Prednisone) If yes: _____

As a child did you have a restricted diet, or were you allergic to any foods? If yes: _____

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never	Amount		5-7x/wk	3-5x/wk	1-3x/wk	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Exercise	<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"/>	_____		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs
Soda/Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep	<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"/>	_____		5+	4	3	2
Rec. Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meals / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							8+ cups	4-7 cups	2-4 cups	<8 oz
						Water / day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you no longer consume the above, please note length of consumption and date stopped.

How many times a week do you eat out?: _____ How many times a week do you eat fish? _____

How many times a week do you eat raw nuts or seeds?: _____

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

STRESS LEVEL: Very High High Medium Low

Have you ever been married or in a long-term relationship? Y N Length of Relationship _____

Have you ever been divorced or ended a long-term relationship? Y N How recently: _____

Have you lived or traveled outside of the United States? Y N If yes: Where _____

Do you have any pets or farm animals? Y N If yes: _____

You are interested in the following services: Chiropractic Nutrition Gluten Issues Thyroid Dysfunction

Weight-loss Cholesterol Issues Pain Management Other _____

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.

Client Name (Printed)

Client Signature

Date

Parent and/or Guardian Printed

Parent and/or Guardian Signature