Patient Initial Form

Name_____ Date_____ Age _____

Date of Birth____/____/_____ Height:_____Weight:_____Marital Status_____

Sex: Male / Female

Address: _____ City_____ State_____ Zip_____

Phone_____ (Circle: home/work/cell) E-mail_____

Are you on probation or parole? Yes or No

What is your occupation? _____

How did you hear about us? _____

Which treatments have you tried to treat your problems? *Circle all that apply*

Surgery Counseling Physical Therapy Chiropractic Care Acupuncture

Homeopathy None Other _____

Have you ever been admitted to the hospital? Yes/No If Yes, give details and Dates:

_____

_____

Are you taking any prescription medications? Yes/No If yes, please list _____

_____

Do you have any allergies to medications? Yes/No If yes, please identify

_____

Do you smoke tobacco? Yes / No Do you drink alcohol? Yes / No Are you pregnant? Yes / No

Do you currently use cannabis (marijuana) for your medical condition? Yes/No/Tried It

How does cannabis compare with other medication that you take for your medical problem?

_____

Have you ever been exposed to asbestos, chemicals, poisons, or radiation (besides X-rays) Yes/No

Are there health/medical problems that occur frequently in your family? Yes/No

If yes, please explain: _____

MEDICAL CONDITONS (Check only what applies.)

NAME_____ **DATE**_____

☐ Arthritis	☐ Heart disease
☐ Autoimmune disease (Lupus, sjogrens)	☐ High blood pressure
☐ Back or neck pain	☐ HIV/AIDS
☐ Brain disorder (epilepsy, trauma, seizure disorder etc.)	☐ Hyperhidrosis (sweaty palms, feet, etc.)
☐ Breast lesions	☐ Gastrointestinal disorder (ulcers, ulcerative Colitis, Crohn's, IBS, GERD, Diverticulitis, Diverticulosis)
☐ Blood disorder (sickle cell anemia)	☐ Kidney diseases (renal failure, stone's)
☐ Cancer, specify	☐ Liver disease (cirrhosis, hepatitis B or C)
☐ Chronic pain, specify	☐ Lungs disease (asthma, emphysema)
☐ Diabetes	☐ Menstrual disorders (cramps) menopausal syndrome
☐ Dystonia (tremors, Parkinson's, Tourette syndrome)	☐ Migraine headaches
☐ Ear problem (tinnitus, hearing loss)	☐ Multiple sclerosis (neurodegenerative disease)
☐ Eating disorder (anorexia, bulimia, nausea)	☐ Neuropathy, restless leg syndrome
☐ Endocrine problems (thyroid, hormones)	☐ Psychological (Depression, Anxiety, ADHD,PTSD, Bipolar disorder, schizophrenia, OCD)
☐ Eye Problems (glaucoma, cataracts)	☐ Skin disorder (psoriasis, eczema)
☐ Fibromyalgia	☐ Sleeping disorder (insomnia)
☐ Gout	☐ Substance abuse (tobacco, alcohol, other drugs)
☐ Urogenital/GYN problems/overactive bladder/enlarged prostate	☐ Weight loss/gain
☐ Other	☐ Pregnant