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# PATIENT PROFILE

**To my patients:** In order to give you the best care possible, I need a complete picture of you physically, mentally, and emotionally. Please answer all of the questions truthfully and completely. All information is strictly confidential. Please write legibly and mark any questions you do not understand with a question mark. If you need more room to answer, please attach the additional information. Thank you!

Whom may we thank for this referral? ____________________

Full Legal Name: ____________________ Date of Birth: __________

Mailing Address: ____________________ Blood Type (if known): __________

City: __________ State: _____ Zip: ______ Home Phone: (_____)__________

Email Address: ____________________

Employer: ____________________ Work Phone: (_____)__________

**Others Living In Household**:

Name: ____________________ Relationship: __________

Name: ____________________ Relationship: __________

Name: ____________________ Relationship: __________

Name: ____________________ Relationship: __________

**Please state reason for visit:** ____________________

____________________

**Hospitalizations:**

Type of illness / operation: ____________ Date: ________ Where: ________

Type of illness / operation: ____________ Date: ________ Where: ________

Type of illness / operation: ____________ Date: ________ Where: ________

Have you had any x-rays taken? YES NO

What kind and when? ____________________

____________________

____________________

Are you allergic to any medicines or substances? YES NO

If yes, please list: ____________________

____________________

____________________

**Patient's Health History:**
For each condition below, please mark a "1" if you now experience symptoms. "2" if you have experienced symptoms in the past, or "3" if you have never had the condition.

____ Alcohol/Drug Abuse
____ Anemia
____ Arthritis
____ Asthma
____ Blood Loss (severe)
____ Cancer
____ Diabetes
____ Digestive Problems
____ Genetic Disorder
____ Heart Problems
____ High Blood Pressure
____ Infections, Chronic
____ Injury to Head or Spine
____ Liver Disorder
____ Mental/Emotional Disorder
____ Nervous System Disease
____ Osteoporosis or Osteopenia
____ Pneumonia/Bronchitis
____ Seizures/Fainting
____ Skin Problems
____ Stomach Problems
____ Thyroid Problems
____ Tuberculosis
____ Urinary Tract Infections

**Family History:**
Has any blood relative had any of the following?

| ✔ = yes<br>blank = no<br>? = don't know | Mother | Father | Sister(s) | Brother(s) | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Maternal Aunt | Maternal Uncle | Paternal Aunt | Paternal Uncle | Maternal Cousin | Paternal Cousin |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcohol/Drug Addiction | | | | | | | | | | | | | | |
| Alzheimer's / Dementia | | | | | | | | | | | | | | |
| Anemia | | | | | | | | | | | | | | |
| Arthritis | | | | | | | | | | | | | | |
| Asthma | | | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | | | | |
| Infections, Chronic | | | | | | | | | | | | | | |
| Mental / Emotional Disorder | | | | | | | | | | | | | | |
| Nervous System Disease | | | | | | | | | | | | | | |
| Osteoporosis / Osteopenia | | | | | | | | | | | | | | |
| Skin Problems | | | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | | | |

*Please answer questions on next page.*

Please list any childhood diseases you had, and any complications:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Please list vaccinations received and when:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Did you have any adverse reactions or change in your general level of health at the time of vaccinations or thereafter? _____Yes _____No

When and where did you last receive health care?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Have you been exposed to any toxic substances? _____Yes _____No
If so, please list:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

How willing are you to change?

______________________________________________________________________
______________________________________________________________________

What medications do you presently take? Include non-prescription medications, dosages, and time of day taken.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

*Please answer questions on next page*

**Health Habits:**

Do you follow a specific diet?

______________________________
______________________________
______________________________
______________________________

What do you do to relax?

______________________________
______________________________
______________________________
______________________________

Do you have any hobbies? ___Yes ___No
If so, please list:

______________________________
______________________________
______________________________
______________________________

Do you participate in some form of exercise?

____Yes ____No
If so, what kind and how often?

______________________________
______________________________
______________________________
______________________________

Do you use tobacco? ____Yes ____No
How much, and for how long?

______________________________
______________________________
______________________________

Do you use alcohol? ____Yes ____No
How often and what kind?

______________________________
______________________________
______________________________

Do you use marijuana or any recreational drugs? ____Yes ____No
What kinds and how often?
(O.K. to give verbal answer.)

Do you drink coffee? ____Yes ____No
How much per day?

______________________________
______________________________

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I understand that payment is due at the time service is rendered unless prior arrangements have been made. By signing this form, I consent to treatment.

______________________________ ______________________
Patient or Responsible Party Date