PATIENT INFORMATION

PATIENT NAME _____ DOB_____ PRONOUN _____

ADDRESS _____ CITY _____ ZIP _____

PARENT(S) _____, _____

TEEN TELEPHONE _____PARENT E-MAIL_____

SCHOOL _____ GRADE _____

PRIMARY PHYSICIAN _____ TELEPHONE _____

EMERGENCY CONTACT _____ TELEPHONE _____

WHO MAY WE THANK FOR REFERRING YOU? _____

What condition would you like to have treated? _____

How long have you had this condition? _____

Have you been treated for this condition? If so, please explain _____

YOUR MEDICAL HISTORY

○ Allergies ○ Asthma ○ Cancer ○ Depression/Anxiety ○ Diabetes ○ Epilepsy ○ Food Allergies
○ Headaches/Migraine ○ Hypertension ○ Skin Condition ○ Digestive Disorders
○ Other _____

Date of last menstrual period _____ Age of first period _____

○ Surgery/Hospitalizations (list) _____
○ Medications/Supplements (list)_____

What is your current stress level? ○ None ○ Minimal ○ Moderate ○ Severe

Do you exercise regularly? ○ No ○ 1-2 times/week ○ 3-5 times/week ○ 5-7 times/week
What type of exercise? ○ Running ○ Bicycling ○ Swimming ○ Yoga/Pilates ○ Walking ○ Weights
Do you play sports? ○ Soccer ○Baseball/Softball ○ Basketball ○ Rowing ○ Swim ○ Track/XC ○ Other

How many hours to you sleep at night? ○ <5 ○ 6 ○ 7 ○ 8 ○ 9 ○ >10

PARENT MEDICAL HISTORY

○ Alcoholism ○ Allergies ○ Arthritis ○ Alzheimer's ○ Cancer ○ Depression ○ Diabetes
○ Headaches ○ Heart Disease ○ Migraines ○ Osteoporosis ○ Stroke
○ Other _____

Parent's Signature _____ **Date** _____