General Contact Information

Anna Maria Irvine, D.C.

Date: _____

Full Name:_____
first middle last

Age: _____ Date of Birth: _____Preferred Pronoun: _____

Home Address: _____City: _____ State: ____ Zip: _____

Best number to contact you: ___Home ___Business ___Cell (____) _____

Okay to leave a message at this number? ___ Y ___ N

E-mail Address:_____

Employed by_____Occupation_____

Marital Status: ___Single ___Married ___In Partnership ___Divorced ___Widowed_____

Name of Spouse/Partner_____ Do you have children? ___Y ___N

Names and Ages of Children: _____

Do they live with you?_____

Pets in Household _____

Primary Care Provider _____

Other Healthcare Providers _____

_____

Emergency Contact: Name _____Relationship_____

Home Phone (____) _____ Cell Phone (____) _____

How did you hear about us? _____

Whom may I thank for referring you? _____

May I use your name in thanking them_____Y ___N

New Client Health Information

Your Name_____ Today's Date _____

Your Birth Date_____

Please list in order of priority your main concerns and how they affect your life?

Lifestyle and Dietary Questions:

Do you smoke **tobacco**? ☐No ☐Yes ☐**Vape**_____

Do you drink **Coffee** or Caffeinated Beverages? ☐ No ☐ Yes Cups per day? _____

Do you drink **alcohol**? ☐ No ☐ Yes How much and How often? _____

How many hours of **sleep** do you get per night on average? _____

Do you do any regular structured **exercise**? ☐ Yes ☐ No
If Yes, what kind and how often_____

_____

How many 8 oz. glasses of ***plain water*** per day _____: ☐ Bottled ☐ Tap ☐ Filtered

Other beverages (list types and number per day) _____

Do you have any **allergies, sensitivities, or intolerances to foods, environmental agents or medications**?

Do you have **dietary restrictions**? (Allergic, religious, vegetarian, vegan)

Please tell me about your **typical diet**.

Typical Breakfast	Typical Lunch	Typical Dinner	Snacks

Medical History: Indicate any **serious conditions, illnesses, injuries, surgeries, or hospitalizations** along with approximate dates.

Please list all current **prescription medications**:

Prescription Medication	Start date	Dosage	Condition being addressed

Please list all current **Nutritional Supplements** including **Vitamins, Herbs and Homeopathy:**

Nutritional Supplement	Start date	Dosage	Condition being addressed by this supplement or herb

How many times have you been treated with antibiotics?

Please list all current **Over the Counter products**: (things you can buy at the drug store)

Please check each of these symptoms that you have currently

GENERAL SYMPTOMS		Ear Noises		**GENITO-URINARY**	
Dizziness		Enlarged Thyroid		Blood in Urine	
Fainting		Eye Pain		Frequent Urination	
Falls		Frequent Colds		Kidney Infection	
Headache		Hearing Difficulty		Loss of Bladder Control	
Nervousness		Hay Fever		Painful Urination	
Numbness		Nose Bleeds		**SKIN OR ALLERGIES**	
Wheezing		Pain Behind Eyes		Allergy	
MUSCLES & JOINTS		Poor Vision		Bruising Easily	
Arm Problems		Ringing in Ears		Dryness	
Broken Bones		Sinus Pain/ Infections		Eczema/Rash/Dermatitis	
Leg Problems		Sore Throats		Hives	
Low Back Problems		**GASTRO-INTESTINAL**		**NERVOUS SYSTEM**	
Neck Problems		Abdominal Pain		Cold/Tingling Extremities	
Pain between Shoulders		Belching/Gas		Dizziness	
Painful Joints		Constipation		Fainting	
Sore Muscles		Diarrhea		Forgetfulness	
Sprains/Strains		Excessive Hunger		Numbness	
Stiff Joints		Excessive Thirst		Paralysis	
Swollen Joints		Gall Bladder Trouble		**FOR WOMEN**	
Weak Muscles		Hemorrhoids		Birth Control Pills	
Walking Problems		Liver/Gallbladder		Hormone Replacement	
CARDIO-VASCULAR		Nausea		Cramps/Backaches	
High Blood Pressure		Ulcer		Excessive Flow	
Heart Attack		Poor Appetite		Hot Flashes	
Heart Trouble		Poor Digestion		Irregular Cycle	
Poor Circulation		Vomiting		Painful Periods	
Rapid/ Slow Heart		Bloody Stool		Breast Pain	
Strokes		Weight Loss/Gain		Pregnant at this Time Y/N	
Swelling Ankles		**RESPIRATORY**			
Varicose Veins		Asthma			
EAR/NOSE/THROAT		Chronic Cough			
Earache		Difficulty Breathing			

Please tell me about your family health history:

Family Member	Current Age	If Deceased, Age & Cause
Mother		
Father		
Siblings		
Children		
Spouse or Partner		

Please indicate if there is a family history of any of these conditions within your immediate family (Siblings, parents, aunts, uncles, grandparents)

Condition	List of Family Members
Alcoholism	
Cancer	
Dementia	
Depression	
Diabetes	
Drug abuse	
Heart disease	
Mental illness	

Please complete the following questions to help me gain a greater understanding of your current circumstances.

Do you feel nourished by:	Yes	No	Describe
Your work?			
Your spouse or partner?			
Your spiritual life?			
Other sources?			

What brings you the most joy in your life?

Are you happy? If not, what would you need to change to be happier?

What causes you the most stress in your life?

How does stress affect you? (Where and how do you feel it?)

What needs to change to reduce the impact stress is having on you?

Do you have a good support system available to you? (e.g. friends, family support groups?)

What are your goals for coming here? Please be detailed and identify milestones that will help you evaluate your progress:

Are there any obstacles you can anticipate that will interfere with my ability to help you achieve the goals you outlined?

What is your definition of good health?

Is there anything not covered on this form that you would like me to know about you?

The information and statements on this health history and information form are accurate to the best of my knowledge.

X_____ Date_____

Signature of Client