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Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition but they may affect your diagnosis and treatment. All information is confidential.

Date	Name	Nickname
Date of Birth	referred by:	Preferred contact method e-mail text phone
Address		
e-mail		Phone

Cancellation Policy: I acknowledge that I will give at least 24 hours notice of cancellation to avoid a charge for the treatment. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 10 minutes late. _____ **Please Initial**

Major Complaints - include severity on a scale of 1 - 10

1. _____

2. _____

3. _____

How long have you had this condition?		What was the initial cause?	
Does it bother your	sleep	work/activities	other (please list)
What makes it better?			
What makes it worse?			

Medical History

Circle any of the following conditions you currently have or have had in the past:

Cancer	Seizures/ Epilepsy	Hepatitis	AIDS/HIV
Thyroid Disorder	Diabetes	High Blood Pressure	Heart Disease
Ulcers	Headaches/Migraine	Immune Disorder: _____	
Insomnia	IBS/IBD	Fatigue	

Any family history of the above conditions? _____

Injuries/Surgeries you have/have had and year diagnosed	Allergies	Medications name/purpose/frequency