

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Best phone to reach you \_\_\_\_\_ DOB \_\_\_\_\_

Please list your main concerns, in order of importance to you:

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What therapies/medications have you used to treat these symptoms?

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Please list all surgeries, illnesses, and major health issues you've had.

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Please list all medications you are currently taking:

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Please list all practitioners you are currently seeing:

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Are pregnant? \_\_\_ Do you have a pacemaker? \_\_\_ Artificial joint? \_\_\_

Any known allergies? \_\_\_\_\_