HMC- Patient Information

Name: _____ Today's Date: _____

Address: _____ City: _____

State _____ Zip Code: _____

Telephone (home/business/cell): _____

Occupation(s): _____ Year(s): _____ Hours/week: _____

Status (please circle): single married common law other

Number of children: _____ Number of siblings _____

Birth Date: _____ Age: _____ Referred by: _____

Education (last grade or degree completed): _____

Reason for Visit: _____

_____

What do you expect from this visit: _____

_____

Are you willing to make life style and diet changes _____

Surgeries (including appendix, wisdom teeth extractions, etc.) and **Date**	**Accidents** (car, trauma, etc.) and **Date**

Medications (current and the past 2 yrs.)	**Medications Cont'd.** current + past 2 yrs.

Supplements (vitamin & minerals, herbal,	Homeopathics, etc.

Email: _____

How did you hear about us? _____

May we email you our newsletter? _____ and information on upcoming events? _____

Family History (please specify type and family member):

Cancer		Obesity	
Heart Disease		Alcoholism	
Diabetes		Mental Illness	
Allergies		Depression	
Stomach/Intestine Complaints		Seizures	

Last: General check-up _____ Dental check-up _____

Eye check-up _____

Major Stressor/Trauma: _____

Serious Infections (i.e. TB, mono, pneumonia, chronic bronchitis, etc.):

_____

Allergies: _____

Have you had long visits or lived in a foreign country (if Yes, how long ago):

_____

Use (please circle): Cigarettes Coffee

Alcohol Recreational Drug(s)

How do you feel after drinking coffee (please circle):

No effect Racing Heart Beat

Hands Shake Light-headed feeling

Sleep: time you retire _____ time you wake up _____

Do you have problems getting to sleep _____

Staying asleep _____

Do you remember nightly dreams? : _____

Exercise (hours/week): **0** **1** **2** **>3**

Weight: Have you experienced changes in weight (increase/decrease) during the past year? (if Yes, by about how much)

_____

Do you suffer from pain? _____

_____