

New Patient Information



Name: _____ Date: _____

Age: _____ Date of Birth: ____ - ____ - _____

Phone: (_____) _____ - _____

Email: _____ @ _____ . _____

Mailing Address: _____
_____ Zip Code: _____

Occupation: _____ For How Long: _____

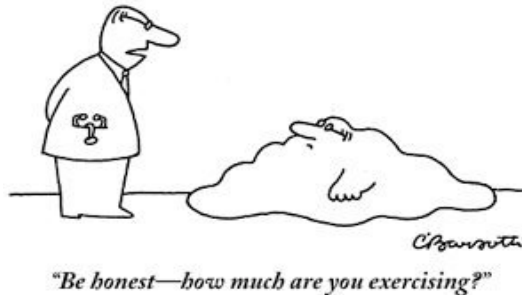
Did someone refer you to our clinic? If so, please let us know so that we can thank them for giving us such a wonderful compliment: _____

Please describe what's going on and what result you'd like to achieve:

In your opinion, how would you rate your overall level of health (1-10)? _____

Do you have any other health goals/concerns? _____

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Current Health Habits:

- Smoker (*Daily, Occasionally*)
- Poor diet
- Alcohol (*Daily, Socially*)
- Using recreational drugs

- Using artificial sweeteners
- No exercise program
- Work-related stress
- Other: _____

- Emotional stress
- Family stress
- Yearly flu shots
- Stomach-sleeper

Some questions regarding the problem you'd like help with...



How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

How does this problem interfere with the following area of your life? *(if applicable)*

Work: _____ Hobbies: _____

Family: _____ Life: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

How much older does it make you feel? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment to solving this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem: ___ *Constant* ___ *Off & On* ___ *Daily* ___ *Weekly* ___ *Monthly*

What, if any, is the effect that it has on your other body functions? _____

Do you remember how it started? _____

If you are on any type of medication, *please list them here, including over-the-counter remedies:*

Have you ever been knocked unconscious or suffered from a concussion? ___ **Yes** ___ **No**

Would you like to receive a complementary gift certificate for a friend or family member to be examined by Dr. Tanase within the next 28 days? ___ **Yes** ___ **No**

Is there any other information that you would like us to know? _____

SIGNATURE: _____ **DATE:** _____

For Women Only

Are you using any means of contraception? ___ **Yes** ___ **No**

Do you experience severe cramping with your menstrual period? ___ **Yes** ___ **No**

Date of your last menstrual period: _____