# PATIENT INFORMATION FORM

TODAY'S DATE: ______________________________

NAME: __________________________________________ DOB: __________________________ SEX: _________

ADDRESS: ________________________________________ CITY: __________________________ STATE: _______

ZIP CODE: ________________________________________ HOME PHONE: ______________________________

CELL PHONE: _____________________________________ E-MAIL: _____________________________________

IN CASE OF EMERGENCY CONTACT INFORMATION:
NAME: __________________________________________ PHONE NUMBER: ____________________________

WHO MAY WE THANK FOR REFERRING YOU? _________________________________________________________

ARE YOU ON ANY MEDICATIONS, SUPPLEMENTS AND/OR VITAMINS? ___________________________________

IF YES, PLEASE LIST NAMES & MG TAKEN DAILY: ___________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

PLEASE LIST ANY PHYSICAL ISSUES YOU ARE EXPERIENCING (whether or not they relate to the current issue):__________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

PLEASE EXPLAIN REASONS FOR APPOINTMENT: ______________________________________________________

_______________________________________________________________________________________________

HOW LONG HAVE YOU BEEN EXPERIENCING THIS ISSUE: ______________________________________________

DO YOU KNOW THE SOURCE OR CAUSE OF ISSUE (yes or no):_______________________ IF SO, PLEASE EXPLAIN:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

WHAT SYMPTOMS ARE YOUEXPERIENCING WITH THIS ISSUE: ___________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

IF EXPERIENCING PHYSICAL PAIN, ON A SCALE OF 1-10, HOW WOULD YOU RATE YOUR PAIN? ________________

IF EXPERIENCING EMOTIONAL UPSET, ON A SCALE OF 1-10 HOW WOULD YOU RATE YOUR EMOTIONAL INTENSITY? _________________________________________________________________________________

HAVE YOU SOUGHT PROFESSIONAL ASSISTANCE WITH THIS ISSUE BEFORE? (yes or no)_____________________

IF YES, WHAT TYPE OF THERAPY HAVE YOU EXPERIENCED: ______________________________________________

DID YOU FIND THIS OR THESE THERAPIES EFFECTIVE? (Please explain) ____________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

HAVE YOU EXPERIENCED ANY OTHER TYPES OF HOLISTIC HEALTH CARE? (yes or no) ________________________

IF YES, PLEASE LIST WHICH TYPES: (examples include: acupunctures, massage therapy, EMDR, NET, etc.)
_______________________________________________________________________________________________

PLEASE EXPLAIN WHAT YOU WOULD LIKE TO ACHIEVE FROMTHIS APPOINTMENT: __________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**I GIVE MYSELF PERMISSION TO LET GO OF ANY PHYSICAL, MENTAL, EMOTIONAL ISSUE THAT KEEPS ME FROM LIVING THE LIFE THAT I DERSERVE.**

SIGN HERE: _______________________________________________________ DATE: _______________________

**PRACTITIONER'S NOTES:**