Health Pointe Jacksonville, LLC

Confidential Patient Information

Name ______________________________ Date ______________ Age ________

Address ____

Gender __________ Birth Date ______________ Social Security # ______________________

Email ______________________ Would you like to receive our newsletter? Y____ N____

Occupation ______________________ Phone ______________________

Referred by ______________________ Marital Status ____________

In case of emergency ______________________ Phone ______________________

Primary Care Physician ______________________ Phone ______________________

What brought you to the clinic today? ______________________________________

____

Review of Systems: Please write in a number; 1.Presently Have 2.Previously Had 3.Related to Accident

General
___Allergies
___Bruise easily
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight-loss/gain
___Nervousness
___Neuralgia
___Numbness
___Sweats
___Tremors
___Anxiety/Depression

Eyes, Ears, Nose, Throat
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Hoarseness
___Gum trouble
___Nasal obstruction

Musculoskeletal
___Arthritis
___Bursitis
___Foot trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain

Pain or numbness in:
___Shoulders
___Arms
___Elbows
___Hands
___Hips
___Legs
___Knees
___Ankles
___Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

Genito-urinary
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Hot flashes
___Painful menstruation
___Irregular cycle

Cardiovascular
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Swelling of ankles

Respiratory
___Wheezing
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm

Gastrointestinal
___Poor appetite
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Heartburn/reflux
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver problems
___Nausea
___Pain over stomach
___Vomiting

Patient Name ______________________________ Date ______________

Current Medication: Please list the names and dosages. (All vitamins, supplements, and over-the-counter)

1.______________________ **5.**______________________
2.______________________ **6.**______________________
3.______________________ **7.**______________________
4.______________________ **8.**______________________

Allergies: medications, food, environmental etc.

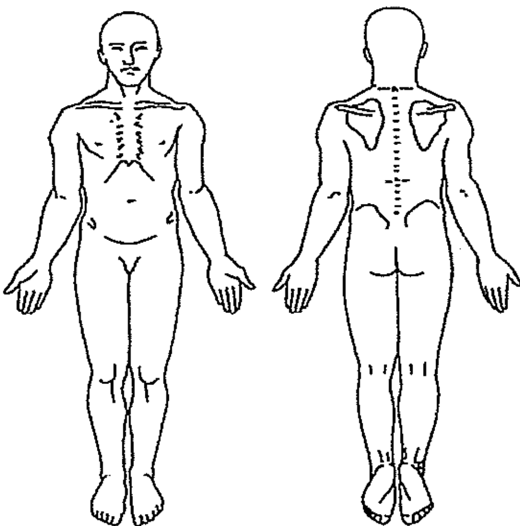
____
____
____

Family History: Please check any of the following that you aware of.

Relatives	Arthritis	Cancer	Stroke/Heart Disease	Kidney Disease	Diabetes	Thyroid Disease	Neurological Disease
Father							
Mother							
Brother/Sister							
Grandparents							

Mark the areas on the diagram with the appropriate symbols for the sensations that you feel. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Sharp / Stabbing
+++++	00000	xxxxx	*****	/////



PLEASE CIRCLE YOUR LEVEL OF PAIN BELOW:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY
1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST
1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY
1 2 3 4 5 6 7 8 9 10

Doctor Only:

Patient Name____ Date____________________

Nutritional Information

Please indicate what you eat in a typical week ☐Breakfast ☐Lunch ☐Dinner #Snacks_______

Indicate the estimated number of servings of each of the following items consumed in a ***typical week***

___Eggs	___Red Meat	___Nuts/Seeds	___Butter	___Spicy Food
___Cheese	___Pork/Ham/Bacon	___Nut Butter	___Margarine	___Junk Food
___Milk (type______)	___Chicken/Turkey	___Fruits	___Olive oil	___Fast Food
___Yogurt	___Fish	___Vegetables	___Canola oil	___Desserts
___Sour Cream	___Beans	___Rice/Pasta	___Corn oil	___Other________
___Ice Cream	___Tofu/Soy	___Bread/Cereal	___Sunflower oil	___Other________
___Lunch Meats	___Other oil________	___Other________		

Any foods not listed and consumed regularly ____

Indicate the estimated number of servings (6-8oz cups) of the following consumed in a ***typical day***

___Caffeinated Coffee	___Green Tea	___Water
___Decaffeinated Coffee	___Regular Soft Drinks	___Fruit Juice
___Regular Tea	___Diet Soft Drinks	___Sports Drinks
___Herbal Tea	___Diet Drinks / Aids	___Other__________

Any drinks not listed and consumed regularly ____

On a scale of 1-10 (10 being extremely healthful), how healthful do you rate you diet? ____/10

If you try to follow a specific diet, please describe the diet and why you follow this type of diet:

____

____

If you would like to have a wellness consultation, please indicate any specific goals and/or questions:

____

____

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance:

____

____

Personal Habits

Please rate

	1-2 x's/week	3-4 x's/week	5 or more x's	Elaborate
Exercise				
Drink Alcohol				
Smoke				
Recreational Drugs				
Chew Tobacco				
Experience Stress				
Other				

I affirm that I have stated all of my known medical conditions, and answered all questions truthfully. I agree to keep the practitioner updated as to any changes in my medical information and understand that there shall be no liability on the practitioner's part should I not do so. I understand that any information discussed during my session is for educational purposes and is not in any way to take the place of medical advice from my doctor.

Name ______________________________ Date ____________________

Witness ______________________________ Date ____________________

Consent to Treatment of Minor: By my signature below, I hereby authorize to administer any therapies to my child or dependent as they deem necessary.

Signature of Parent or guardian ______________________ Date ____________________

Witness ______________________________ Date ____________________

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