Patient History

Name: **Date of Birth:**
Address:
Phone:
Email: **Occupation:**
Primary Care Physician:
Signature: **Today's Date:**

Current Symptoms (e.g. intermittent pain left knee for 6 months aggravated by walking, relieved by rest)**:**

Clinical Concerns (e.g. spine/nerve/disc issues, arthritis, obesity, diet, organ functioning, etc.)**:**

Current Treatment (e.g. physical therapy, chiropractic, massage)**:**

Current Medication(s) (include bio-identical hormones, beta blockers, anti-inflammatories, etc.)**:**

Family History (e.g. cardiovascular disease, hypertension, diabetes, cancer, etc.)**:**

Surgical History (e.g. appendix, hernia, thyroid, gallbladder, kidney stone removal, cosmetic, C-section)**:**

General History (e.g. injuries, accidents, diseases, conditions, high risk issues, chemical exposure, smoking, etc.)**:**

Mammogram/Ultrasound History:

Ob/Gyn History (e.g. ovarian/uterine cysts, endometriosis, hysterectomy, cervical cancer, etc.)**:**

Dental History (e.g. amalgam fillings, root canal/crown(s), implants, dentures, gum disease, etc.)**:**

Diagnoses (condition/date)**:**

Thermogram History:
Previous Report #'s:
Results of clinical correlation (results/findings of ultrasound, mammogram, biopsy, etc.)**:**

Skin Lesions or Physical Abnormalities (e.g. moles, scars, tattoos, piercings, wounds, lipomas etc.)**:**