

Lozier Natural Health Center

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Today's Date: _____ Age _____ Sex _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____/____/____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Email Address _____
Your Occupation _____ Your Employer: _____
Social Security #: _____
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone :(____) _____
Referred to this Office by: _____

Have you been treated by a physician for any health condition in the last year? Yes No
If yes by whom _____
Describe Condition _____ Date of Last Physical Exam _____

Surgical History:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate pain (1-10, 0-no pain to 10 worst pain)

	#
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Have you received Chiropractic care before? YES NO
Are you currently receiving chiropractic care? YES NO

What medications are you currently taking?

What nutritional supplements are you currently taking?

Are you pregnant? Yes No Date of last menstrual period _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

Lozier Natural Health Center

What do you know about our approach?

What *three* expectations do you have from *this* visit?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 1 2 3 4 5 6 7 8 9 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

Patient Name _____ Date _____

For your 1st visit-checkmark any symptom you have experienced in the last month. **For Re-exams**-checkmark symptoms you are currently experiencing.

HEADACHES

___ Base of Skull (back)

___ Side of head (Temples)

___ Frontal (above eyes)

___ Top of head

___ Entire Head

___ Migraines

___ TMJ

___ Cluster

___ Other _____

CHEST

___ Tension

___ Tight

___ Pressure

___ Heaviness

___ Anxiety

___ Congestion

___ Chest Pain

___ Sternal Pain

___ Sharp Heart Pain

___ Palpitations-Heart Skip/Flutter

___ Mitral Valve Prolapse

___ Tachycardia/Heart Racing

___ Bradycardia/Heart Slowing down

___ Murmur

___ Arm Pain

___ Other _____

For Men Only: PROSTATE

___ History

___ Current

___ Burn

___ Achyness

___ Pain

___ Restriction

___ Dribbling

___ Emission

___ Swelling

___ Other _____

CRAMPS/ ACHES/ RESTLESS

___ Cramps (legs/feet/arms/hands)

___ Aches (legs/feet/arms/hands)

___ Restless (legs/feet/arms/hands)

ENERGY

___ Low

___ Variable

___ Normal

___ High

___ Slow to start in the morning

___ Energy Crash _____ am/pm

___ Low Energy after meals

___ Other _____

EARS

___ Noise (Ring/Hiss/Pound)

___ Plugged

___ Popping

___ Ear Ache

___ Ear Infections

___ Draining

___ Itchy

___ Hearing Loss

___ Dizziness/ Vertigo

___ Excessive Ear Wax

___ Other _____

SHORTNESS OF BREATH

___ Constant

___ Upon Exertion

___ Asthma

___ Wheezing

___ Air Hunger/ Frequent Sighs

___ Yawning

___ Emphysema

___ Other _____

VAGINA (women only)

___ Burn

___ Itch

___ Dry

___ Pain

___ Pain with intercourse

___ Blood

___ Discharge

___ - Clear

___ - White

___ - Yellow

___ - Green

___ - Brown

___ - Odor

___ Other _____

SKIN/ HAIR/ NAILS

___ Skin Rash

___ Acne

___ Dry Skin

___ Itchy Skin

___ Fungus

___ Patches skin look different

___ Cellulite

___ Nails (weak/ spots/ lines)

___ Hair loss

___ Limp Hair

___ Cherry Hemangiomas

___ Slow Healing

___ Bruise Easily

___ Other _____

EXERCISE

___ Cardiovascular _____ times/ week

___ Weight Train _____ times/per week

MEMORY

___ Short Term Loss

___ Long Term Loss

___ Forget Names

___ Forget Numbers

___ Forget Words

___ Forget Actions

___ Difficulty Concentrating

___ Other _____

EYES

___ Burn

___ Tear

___ Ache

___ Red

___ Dry

___ Eye Film

___ Crust in morning

___ Itchy Eyes

___ Bouts of Blurriness

___ Floaters

___ Spots

___ Tired

___ Puffy

___ Sty

___ Twitching around eyes

___ Dark Circles

___ Light Bothers Eyes

___ Nearsighted

___ Farsighted

___ Other _____

STOMACH

___ Heartburn

___ Indigestion

___ Stomach Aches

___ Stomach Cramps

___ Nausea/ Queasy

___ Bloat after Eat

___ Gas/ Flatulence

___ Belching

___ Ulcer

___ Hiatal Hernia

___ Other _____

MENSES (women only)

___ Last Menstrual Period _____

___ Length of Menses _____

___ Regular

___ Irregular

___ Early (less than 28 days)

___ Late (more than 28 days)

___ Skip

___ Birth Control Pill

___ Flow (heavy/ moderate/ light)

___ Cramps (mild/ mod/ severe)

___ Low Abdominal Puffiness

___ Fluid Retention Face

___ Fluid Retention Hands

___ Fluid Retention Feet

___ Fluid Retention Body

___ Breast Tender around cycle

___ Acne (pre/mid/post)

___ Clotting

___ Spotting

___ PMS

___ Mood Swings

___ Irritable

___ Depression

___ Tired during period

___ Pain during Ovulation

___ Cysts/PCOS

___ Discharge with Ovulation

___ Regular Ovulation

___ Irregular Ovulation

___ Fibroids

___ Facial Hair

___ Hair growing up towards belly button

___ Dark Nipple Hair

___ Other _____

URINATION

___ _____ times per day-frequency

___ Urinate at night _____ per night

___ Frequency

___ Urgency

___ Burning

___ Pain

___ Odor

___ Spasm

___ Leakage

___ Urinary Tract Infection

___ Kidney Troubles

___ Other _____

LIBIDO/ SEXUALITY

___ Flat

___ Low

___ Normal

___ Erectile Dysfunction (men)

___ Orgasm Quality (poor/ good/ great)

___ Other _____

SINUS

___ Dry

___ Drain

___ Stuffy/ plugged up

___ Post nasal drip...circle color:
___ white/yellow/green/gray
___ brown/blood/blood/clear

___ Excessive Sneezing

___ Loss of Smell

___ Loss of Taste

___ Thirsty

___ Not Thirsty

___ Unquenchable thirst

___ Other _____

BOWELS

___ Bowel Movements _____ Per day

___ Regular

___ Incomplete

___ Skip days _____ per (week/month)

___ Sluggish bowels every _____ days

___ Cramps in Abdomen

___ Taking Laxatives

___ Using Suppositories

___ Enemas

___ Colonics

___ Take Herbal Laxatives/Supplements

___ Bulky

___ Pain with Bowel Movements

___ Irritable Bowel Syndrome

___ Chrons

___ Colitis

___ Other _____

BREASTS (women only)

___ Breast Feeding

___ Fibrosis

___ Lump

___ Discharge

___ Prosthesis

___ Augmentation Surgery

___ Reduction Surgery

___ Pathology

___ Breast Tender constant

___ Other _____

SLEEP

___ Quality (poor/fair/good/great)

___ _____ Hours in bed

___ _____ Hours asleep

___ Difficulty falling asleep

___ Difficulty staying asleep

___ Interrupted _____ per night

___ Crave Sleep during day

___ Awaken Suddenly (Jolt)

___ Don't Remember Dreams

___ Nightmares

___ Night sweats

___ Restlessness

___ Sleep Apnea

___ Other _____

**PAIN/ STIFFNESS/ SWELLING
NUMBNESS/ TINGLING**

___ Facial

___ Neck

___ Trapezius

___ Upper Back

___ Shoulders

___ Arms

___ Elbows

___ Wrist

___ Hand

___ Mid Back

___ Low Back

___ Sacral Iliac

___ Hips

___ Buttocks

___ Legs

___ Sciatica

___ Knees

___ Ankles

___ Feet

MOUTH/ THROAT/ IMMUNE

___ Sore Throat

___ Hoarseness

___ Cough (dry/productive)

___ Allergies

___ Upper Respiratory Infection

___ Teeth Health Problems

___ Fever

___ Chills

___ Bad Breath

___ Canker Sores

___ Blisters

___ Frequent Colds/ Flu

___ Neck Stiffness

___ Shoulder Tension

___ Cracks at lip corners/ Chielosis

___ Dry Mouth

___ Cold sweaty hands & feet

___ Bleeding gums

___ Receding gums

___ Teeth Health Problems

FECAL CONSISTENCY

___ Color feces light or dark _____

___ Soft/Unformed

___ Ribbon-like

___ Mucous

___ Normal/ Banana Shaped

___ Hard

___ Pebbles

___ Dry

___ Painful

___ Diarrhea

___ Constipation

___ Broken

___ Other _____

BREASTS (women only)

___ Breast Feeding

___ Fibrosis

___ Lump

___ Discharge

___ Prosthesis

___ Augmentation Surgery

___ Reduction Surgery

___ Pathology

___ Breast Tender constant

___ Other _____

EMOTIONS

___ Stressed

___ Sad

___ Grief

___ Depression

___ Moodiness

___ Irritable

___ Worrisome

___ Angry

___ Nervous

___ Frustrated

___ Anxiety

___ Panic

___ Cry

___ Fear

___ Shame

**List Your Primary Concerns
in order of importance to you:**

1) _____

2) _____

3) _____

4) _____

HEMORRHOIDS

___ History

___ Current

___ Swollen

___ Burn

___ Blood

___ Distended

MENOPAUSE (women only)

___ Natural

___ Surgical (partial/complete)

___ Hormones

___ Patch

APPETITE/ DIET

___ Low Appetite

___ Normal Appetite

___ High Appetite

___ Starch (pasta/bread/potatoes/rice)

___ Sweets

___ Chocolate

___ Coffee _____ cups/ day

___ Caffeinated Tea _____ cups/day

___ Beer _____ per week

___ Wine _____ per week

___ Juice _____ per week

___ Soda _____ per week

___ Artificial Sweeteners

For Doctor's Use

___ Frenular Cyst

___ Cracks in Tongue

___ Allergy Patches Tongue

___ Geographic Tongue

___ Red Spots Tongue

___ Swollen Tongue

___ Color Tongue _____

___ Dark Veins Tongue

___ Coated Tongue (mild/mod/severe)

___ Ear Creases (R/ L) mild/mod/severe

___ Weight _____ (+/- lbs) overall (+/-) _____

___ Height _____

___ Pulse _____ BP: (____/____)

___ saliva pH _____ Urine pH _____

___ Allergies _____

___ Current Meds: _____

Website Member Wellness Registration

To become a registered member with our office simply fill out the form below. Once your membership request has been approved, you will be notified via email. Please make sure the email address you provide is accurate. Form fields marked with an * are required for registration.

Please note that we respect your privacy, and will not loan, sell, or otherwise distribute your personal information to any third party.

General Information:

*First Name: _____ *Last Name: _____

*Address: _____

*City: _____ State: _____ *Zip: _____ *Country: _____

*Phone: _____ Fax: _____

*E-Mail Address: _____

Member Log-In:

*Username: _____

*Password: _____

Yes, I would like to receive special offers or cards on my birthday.

Birthday: _____ / _____ / _____

Yes, I would like to receive special announcements from the office and a free subscription to the Healthy Living Newsletter.

Check off topics of interest:

Backaches & Sciatica

Headaches & Neck Pain

Wellness Topics

Diet & Nutrition

Exercise & Fitness

Women's Health Issues

Children's Health Issues

Stress Management

Doctor's Announcements