



NEW CLIENT INFORMATION

Today's Date _____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Marital Status S__ M__ D__ W__ Other _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ E-mail: _____

Occupation: _____ Employer/School: _____

Work Phone: (_____) _____ Work Status: Full-Time__ Part-Time__ Seasonal__ Other _____

In case of an Emergency – Contact: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? _____

General Information:

Height: _____ Weight: _____ Recent Weight Loss __ / Gain __? Amount? _____ lbs.

Reason/method for weight loss/gain: _____ Number of Bowel Movements/Day: _____

Difficulty Falling asleep? Y__ N__ Difficulty Staying Asleep Y__ N__ Tired after full night's sleep? Y__ N__

Lightheaded/Irritable When Hungry? Y__ N__ Crave sugar/salt? Y__ N__ Fatigue after meals? Y__ N__

Need coffee/sweets 3-4pm? Y__ N__ Do you eat Breakfast? Y__ N__ Do you eat snacks b/t meals Y__ N__

Usual Breakfast: _____

Usual Lunch: _____

Usual Dinner: _____

Usual Snack: _____

Do you have any dietary restrictions? Food allergies? Y__ N__ Please explain: (Paleo, vegetarian, gluten, dairy intolerance, Kosher, etc.) _____

CLIENT NAME: _____

Women Only:

Is there any chance you might be pregnant? Y__ N__ Date of last Menstrual cycle: _____

Are you experiencing perimenopause? Y__ N__ Reached Menopause? Y__ N__

Are you experiencing symptoms? Y__ N__ Comments: _____

Do you currently, or have you used any of the following? (Please circle all that apply): Birth Control Pills, Hormone Replacement Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive Length of use of each type? _____

Have you ever had an abnormal PAP? Y__ N__ Comments: _____

Age of Menarche (periods began): _____ Age of Children (if any): _____

of pregnancies: _____ # of birth children: _____ # of C-Sections: _____

Health History:

___ Alcoholism

___ Eczema/Psoriasis

___ High Blood Pressure

___ Anemia

___ Epilepsy

___ HIV/AIDS

___ Cancer

___ Goiter

___ Pleurisy

___ Cold sores

___ Gout

___ Pneumonia

___ Deep vein thrombosis

___ Heart disease

___ Stroke

___ Depression/Anxiety

___ Hepatitis A/B/C

___ Tumor(s)

___ Diabetes

___ Herpes

___ Ulcer(s)

Other: _____

Do you wear corrective lenses? Y__ N__ Date of Last check-up/prescription change? _____

Date of most recent physical/annual exam: _____ Did you have blood-work done? Y__ N__

Results/Concerns: _____

Serious Illnesses/Hospitalizations/Surgeries: Please detail (year, reason, outcome) _____



WORK ACTIVITY:

Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving

STRESS LEVEL:

Very High High Medium Low

Have you traveled in the last twelve months? Y__ N__

If yes: Where (especially internationally) _____

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Rinehart at any time!

Participant Name (Printed) *Participant Signature*

Date

Parent and/or Guardian Printed *Parent and/or Guardian Signature*

