A Touch of Health, LLC

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PLEASE PRINT

PERSONAL INFORMATION

NAME____ DATE______________________________

ADDRESS________________________________CITY______________ STATE______ ZIP__________

PHONE___________________ SOC. SEC. NO.__________________ DATE OF BIRTH_________________

EMAIL________________________________ We provide a free informational email about diet and nutrition.

MARITAL STATUS_________SEX_________AGE________NUMBER OF CHILDREN__________________

OCCUPATION__________________________EMPLOYER_________________________________

ADDRESS_____________________CITY/ZIP________________TELEPHONE___________________

NAME OF SPOUSE_________________________ SPOUSE'S OCCUPATION_____________________

EMPLOYER____

ADDRESS_____________________CITY/ZIP________________TELEPHONE___________________

EMERGENCY NOTIFICATION

NAME ____

ADDRESS_____________________CITY/ZIP________________TELEPHONE___________________

REFERRED BY____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned. **If I miss my appointment without giving a 24 hour notice I agree to pay the $35 office fee.**

Date______________ Patient's Signature____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT____

HOW DID IT HAPPEN?____

____

TODAYS CONDITION STARTED WHEN?____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?____________________________________

WHAT ACTIVITIES LESSEN YOUR CONDITION?_______________________________________

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____________________________

IS THIS CONDITION INTERFERING WITH WORK?______ SLEEP?______ ROUTINE? ______________

IS CONDITION GETTING PROGRESSIVELY WORSE?____________________________________

OTHER DOCTORS SEEN FOR THIS CONDITION_______________________________________

TYPE OF TREATMENT______________________________RESULTS____________________

Habits

- ❑ Alcohol: Type___________
  Amount______________
  Diet: Salt intake___________
  Fat intake______________
  Other_______________
- ❑ Sleep: Difficulty falling asleep_________________
  Continuity disturbances_____
  Early morning awakenings___
  Daytime drowsiness________
  Other_________________
- ❑ Smoking: Packs daily______
  How long______________
  Interested in stopping?______
- ❑ Exercise routine:____
  ____
  ____
- ❑ Caffeine: Coffee, cups daily_______________
  Other_______________