Your Healing Is Our Mission - Your Comfort Is Our Goal

Confidential Patient Information

Name: ______________________________ **Date:** __________

Address: ______________________________

City: __________ **State:** __________ **Zip:** __________

Phone: **(Home)** __________ **(Work)** __________ **(Mobile)** __________

Email: ______________________________

Age: ______ **Birth Day:** __________ **Social Security No:** __________

Sex: **M / F** **Marital Status:** Single / Married/ Divorced / Widowed

Occupation: __________ **Employer:** __________

Number of hours worked per week: ______________________________

Spouse's Name: __________ **Phone number:** __________

Number of Children: ______________________________

How did you hear about us: ______________________________

Emergency Contact Information

Emergency Contact: ______________________________

Contact Phone: ______________________________

Relationship to Emergency Contact: ______________________________

Insurance Information

Insurance Company: ______________________________

Policy: ______________________________

Address: ______________________________

Group: ____________________ **Phone Number:** ____________________

Primary Care Physician: ______________________________

Primary Insurance Holder

Name: ______________________________

Insured's SSN: ______________________________

Relationship to Insured: ______________________________

Date Of Birth: ____________________ **Phone Number:** ____________________

Experience with Holistic Medicine

Have you ever been to a Holistic Practitioner? ☐ Yes ☐ No

Please check if you have experienced:

☐	**Acupuncture**	☐	**Aromatherapy**
☐	**Chiropractic Medicine**	☐	**Diet and Lifestyle Modification**
☐	**Functional Medicine**	☐	**Medical Massage**
☐	**Mind-Body Medicine (Biofeedback)**	☐	**Naturopathy**

Reason for those Visit? ______________________________

Was the care helpful? ______________________________

Reason for Visit

Purpose of Appointment: ______________________________

____

When did the conditions begin? ______________________________

Do you remember what caused it? ______________________________

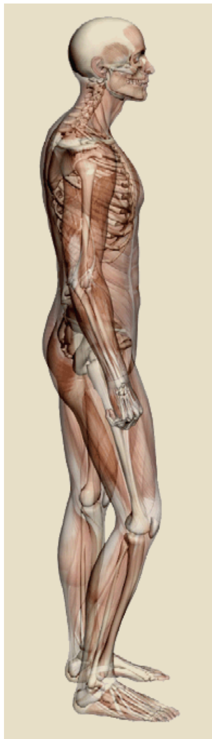
If you have pain, please rate your pain on a scale of 1-10 (10 - severe and 1 - no pain): __________

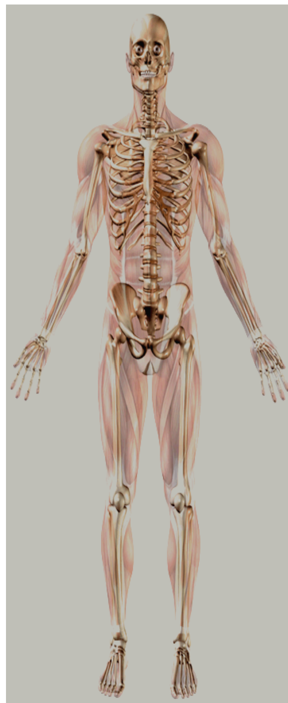
Other Doctors Seen For This Condition: ______________________________

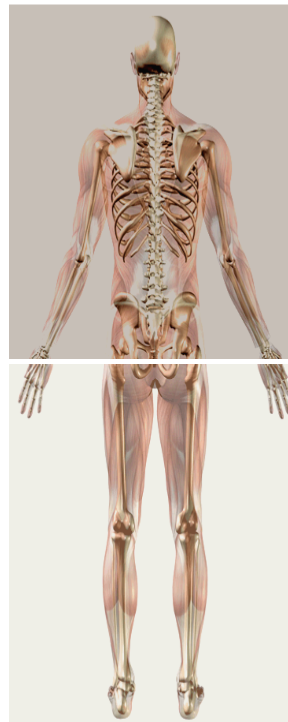
Have you ever been treated for any other condition in the past year? ☐ Yes ☐ No

If so, describe: ______________________________

____







Please mark an "X" to indicate areas where you feel pain, swelling, or discomfort.
Describe what you feel or observe in your own words. Write anywhere in this area.

Health Intake

Height: ______________________ **Weight:** ______________________

Known Allergies ______________________

Blood Type ______________________

Medications/Drugs taking (State reason for each medication):

____

____

Herbs or Supplements: ______________________

____

Do you have allergies to any medication or botanicals/herbs: ☐ Yes ☐ No

If yes, list medications or botanicals/herbs and reaction: ______________________

____

List all Surgeries, Hospitalizations and Serious Illnesses (List year):

____

____

Diagnostic Imaging (CT scan, MRI, MRA, Contrast Studies, X-Rays including dental and Spinal)

Age	Body Area	Type (Normal

Lifestyle Habits

Do you smoke:	☐ Yes ☐ No	**What?**	________	**How Many/day:**	____________
Tobacco Products:	☐ Yes ☐ No	**What?**	________	**How Many/Day:**	____________
Substance Abuse?	☐ Yes ☐ No	**What?**	________	**How Many/Day:**	____________
Drink Coffee?	☐ Yes ☐ No	**Cups/Day**	________		
Drink Tea?	☐ Yes ☐ No	**Cups/Day**	________		
Colas/Soft Drinks?	☐ Yes ☐ No	**No./Day**	________		
Alcohol Drinks?	☐ Yes ☐ No	**Avg./Week**	________		
Water Intake?	☐ Yes ☐ No	**No. of Glasses per day:**	____________		

Do you eat in fast food restaurants? ☐ Yes ☐ No **How many times/week?** ____________

Are you Dieting? ☐ Yes ☐ No **Reasons** ____________________

Bowel Movement Frequency: ________ **Difficulty?** ☐ Yes ☐ No

Do you sleep well? ☐ Yes ☐ No **If No, Describe:** ____________________

____

Do you have Sufficient energy for normal activities? ☐ Yes ☐ No

If No, Describe: ____________________

____

Do you have corrective lenses: ☐ Yes ☐ No **Has your Vision Changed recently?** ☐ Yes ☐ No

Do you wear Heel Lifts or Foot Supports: ☐ Yes ☐ No **Explain:** ____________________

____

Place a "✓" to indicate if you or your family currently have or have had any of the following:

	Self	Family		Self	Family
AIDS/HIV	☐	☐	Herniated Disc	☐	☐
Alcoholism	☐	☐	High Blood Pressure	☐	☐
Allergy	☐	☐	High Cholesterol	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐
Anorexia/Bulemia	☐	☐	Kidney Disease	☐	☐
Anxiety Attacks	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Multiple Sclerosis	☐	☐
Auto Immune Disease	☐	☐	Osteoporosis	☐	☐
Bleeding Disorder	☐	☐	PMS	☐	☐
Breast Lumps	☐	☐	Prostate Problems (men)	☐	☐
Cancer	☐	☐	Psychiatric Care	☐	☐
Celiac Disease	☐	☐	Rheumatoid Arthritis	☐	☐
Chronic Fatigue	☐	☐	Sleep Problems	☐	☐
Crohn's Disease	☐	☐	Stroke	☐	☐
Depression	☐	☐	Thyroid Problems	☐	☐
Diabetes	☐	☐	Tumor/Growth (non-cancer)	☐	☐
Digestion Problems	☐	☐	Ulcers	☐	☐
Fibromyalgia	☐	☐	Vaginal Infections	☐	☐
Gout	☐	☐	Others:		

Release of Information

All information provided herein is true and correct. I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this release. I understand detailed copy of my HIPAA rights can be provided upon request.

X________________________________ Date________________

Payment Policy

Payment of all services rendered is due at the time of service to Holistic Vitality Center, PLLC. I have read and understood this policy.

X________________________________ Date________________

Appointment Cancellation Policy

I understand that 24 hours notice is required when canceling an appointment. I also understand that $30 fee will be charged if I do not cancel 24 hours prior to my appointment.

X________________________________ Date________________