PATIENT HISTORY AND CONTACT INFORMATION

Sex: ☐ Male ☐ Female DOB: _____ Age:_____
Title: _____ First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____ Mobile #: _____
Email: _____

MEDICAL HISTORY

Are you pregnant?	☐ Yes ☐ No
Are you breastfeeding?	☐ Yes ☐ No
Do you have a history of blood clots?	☐ Yes ☐ No
Have you ever suffered a stroke?	☐ Yes ☐ No
Do you have herpes?	☐ Yes ☐ No
Do you have cancer?	☐ Yes ☐ No
Do you have allergies?	☐ Yes ☐ No

If so, please list: _____
_____

Do you suffer from or have a history of:

Anxiety	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Blood Pressure	☐ Yes ☐ No
Cardiac	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Menopause	☐ Yes ☐ No

List your current medications, including mood-altering drugs:
_____
_____

Do you take supplements daily? ☐ Yes ☐ No
If so, please list: _____
_____

OFFICE USE – TO BE FILLED IN BY STAFF
Treatment Advised: _____
Desired Treatment Goals: _____
Height: _____ Current Weight: _____ Goal Weight: _____ Blood Pressure: _____
% of Body Fat: _____ Total Fat: _____ BMI: _____
Hip Measurement: _____ Waist Measurement: _____ Left Thigh: _____ Right Thigh: _____
Notes: _____
_____
_____
_____
_____
_____