

Chris Morris, N.D.
Tina Johnson, AHNC candidate

Patient Information Record

(Please print)

Name _____	Birth Date ____/____/____
_____	Sex ____ Height ____ Weight ____
Address _____	Legal Status
_____	Single Married Divorced Separated
_____	Education (yrs completed)
_____	Elem ____ HS ____ College ____
Phone _____	Voc ____ Prof ____
Home: (____) _____ - _____	Social Security# _____
Work: (____) _____ - _____	Referred by _____
Email Address _____	Interests/Hobbies
Emergency Contact _____	_____
Name: _____	_____
Phone: _____	_____
Relationship: _____	

Lifestyle

List your favorite foods or cravings

Are/Were you a smoker?
(yes or no) _____ Number of years _____ How much? _____
If applicable, when did you quit? _____

Use of coffee:
Number of cups per day _____ Decaf coffee cups per day _____

Mind Body & Spirit

Creating balance in your life

Use of alcohol:

beer _____ wine _____ liquor _____

Use of recreational drugs: (yes or no) _____

If yes which ones _____

I exercise on a regular basis (yes or no) _____ Times per week _____

I find my work:

satisfying _____ too demanding _____ boring _____ very satisfactory _____

I do the following for recreation:

I sleep well (yes or no) _____

I worry about:

money _____ job _____ family _____ relationships _____ other _____

I currently see a mental health professional (yes or no) _____

I currently see a chiropractor, osteopath, rolfer, or another physical therapy professional
(yes or no) _____

Personal History

Current medications

List all prescriptions and non-prescriptions

Vitamin and mineral supplements

Type and dosage

Allergies

Medications and Foods

Family History

For your parents, siblings, and children, list ages, cause of death if deceased, and health problems see below.

<u>Disease</u>	<u>Relationship</u>	<u>Disease</u>	<u>Relationship</u>
Alcohol/drug Problem _____	_____	High blood pressure _____	_____
Allergy/asthma _____	_____	High cholesterol/fat _____	_____
Anemia _____	_____	Kidney disease _____	_____
Arteriosclerosis _____	_____	Liver diseases _____	_____
Binge eating/bulimia _____	_____	Mental illness _____	_____
Bleeding problem _____	_____	Obesity _____	_____
Cancer _____	_____	Stroke _____	_____
Diabetes _____	_____	Thyroid Disease _____	_____
Epilepsy/seizure _____	_____	Tuberculosis _____	_____
Heart Disease _____	_____	Gastro intestinal disease _____	_____
Skin disease _____	_____	Syphilis _____	_____
Endocrine/hormonal imbalance _____	_____	Gonorrhea _____	_____

Past History

List all surgery and approximate dates

Broken Bones and/or traumatic Injuries
(Include all car accidents/concussions)

Other hospitalizations and dates _____ Current health concerns (i.e: high blood)

Menstrual History (females)

Age of onset _____ Flow (heavy, mod, light) _____

Days of flow _____ Length of Cycle _____

Do you have pain and/or cramps with your period? _____

Number of pregnancies _____ Number of live births _____

Number of miscarriages _____ Birth control Method _____

Present Illness

What brings you here today?

What effect has the above had on your lifestyle?

What would you like to achieve in your initial visit with your Practitioner?

What do you expect of your Practitioner?

YOUR SIGNATURE

____/____/____