Lisa Lust-Stewart, D.C., D.A.C.B.N

Patient Information

Thank you for choosing us to help you accomplish your health goals. Please complete this form in ink. If you have any questions or concerns do not hesitate to ask. We will be happy to help. (Please Print)

Name: **Date:**

Last MI First

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Fax: E-Mail:

Would you like to receive e-mailed notifications and information including our newsletter? Yes No

Occupation: Sex: Male Female

Date of Birth: Place of Birth: Age:

Ethnicity: Ethnic Heritage:

Marital Status: S M W D Spouse Name:

Spouse Daytime Phone: Cell Phone:

Emergency Contact Name and Phone Number:

Employer Address City State Zip

Primary Physician Name:

Address: City State Zip

Office Phone: Office Fax:

Whom May We Thank For Referring You?

Name of person responsible for this account?

Symptoms

Reason for visit (Main Complaint)?

When did you first notice your symptoms?

On A Scale of 1(best) - 10 (worst), Rate Your Problem: Is It Getting: Worse Better Same

If You have Pain associated with your symptoms please **circle** the applicable description:

Sharp Dull Stabbing Burning Aching Vague

What Makes It Better?

What Makes It Worse?

How Often Do You Experience These Symptoms?

How Long Do The Symptoms Last When You Have Them?

Any Past Episodes (List Dates and Duration):

What type of treatment have you already received for this condition?

What secondary symptoms are you also experiencing?

What else do you want us to know about this Problem?

Date

Current And Past Health History:

Name: _____ **Page 2**

Please check all applicable past or present and enter the date of onset:

AIDS/HIV		High Blood Pressure	
Alcoholism		Kidney Disease	
Allergies		Liver Disease	
Anemia		Migraine Headaches	
Anorexia/Bulemia		Miscarriage	
Appendicitis		Mononucleosis	
Arthritis (OA,RA,Other)		Multiple Sclerosis	
Asthma		Osteoporosis	
Bleeding Disorders		Pacemaker	
Breast Lump		Parkinson's Disease	
Bronchitis/Pneumonia		Polio	
Cancer		Prostate Problems	
Cataracts		Prosthesis	
Chronic Fatigue		Psychiatric Care	
Depression / Anxiety		Recreational Drugs	
Diabetes		Rheumatic Fever	
Emphysema		Scarlet Fever	
Epilepsy (Seizures)		Stroke	
Fractures		Suicide Attempt	
Glaucoma		Thyroid Problems	
Goiter		Tropical Diseases	
Gonorrhea		Tuberculosis	
Gout		Tumors, Growths	
Heart Disease		Ulcers	
Hepatitis A_B_C_Oth_		Vaccine Reactions	
Hernia		Vaginal Infections	
Herniated Disc		Venereal Disease	
Herpes		Whooping Cough	
High Cholesterol		Other	

Date: _____

Nutritional Information

Name:

Please Enter The Following Information:

Pregnant: Yes No Unsure Pacemaker: Yes No

Children: Yes No Number and Ages:

Habits and /or Excessive Usage

Alcohol:	Yes	No	How Much Daily:	Weekly:
Chocolate	Yes	No	How Much Daily:	Weekly:
Cigarettes/Cigars	Yes	No	How Much Daily:	Weekly:
Coffee/Tea	Yes	No	How Much Daily:	Weekly:
Drugs	Yes	No	How Much Daily:	Weekly:
Exercise	Yes	No	How Much Daily:	Weekly:
Soda/Pop	Yes	No	How Much Daily:	Weekly:
Sugar	Yes	No	How Much Daily:	Weekly:

Sleep Hours/Night Continuous Interrupted

What Time Do You Go To Bed:

Do You Feel Rested When You Wake: Rate Your Quality Of Sleep (1 awful - 10 great):

Have You Ever Visited or Lived In A Foreign Country: Yes No

If Yes Which Ones:

Questions Regarding Your Birth And Infancy:

Was Your Mother Healthy When She Was Pregnant With You? Yes No

If No Please Explain:

Was Your Birth Natural? Yes No If No: Anesthesia Forceps C-Section

Were You Breast Fed For At Least 6 Months: Yes No Unknown

Were You Fed Anything Other Than Milk in The First 6 Months? Yes No

If Yes Please Explain:

Please List Any Health Problems You May Have Had As A Baby:

Childhood Diseases: Measles Chicken Pox Mumps German Measles

Other (please specify):

Which Vaccines, if Any, Have You Had:

Please Describe Any Reactions Or Problems As A Direct Result:

Date:

Nutritional Information

Name: _____

Surgeries & Hospitalization: Please list all surgeries & Hospitalizations, include the dates

Surgery/Hospitalization	Date	Why	Outcome

Traumatic Injuries and/or Major Illnesses: Please include date it happened.

Trauma or Illness	Date	Outcome

Allergies: Please list all your allergies (Food, Drugs and any other Substances)

Allergen	Symptom	How Long Have You Had It?

Current(C) & Past(P) Medications: Please list all your medications and their purpose

Name (C or P)	Dosage	Why Are You Taking?	How Long	Outcome

Current Supplementation: Please all your vitamins and minerals and their purpose

Name	Dosage	Why Are You Taking?	How Long	Outcome

Please Bring Any Diagnostic Tests (ie: Blood Tests, Scans, etc) With You.

Date: _____

Family Information

Name

Please Tell Us About Your Family:

Parents:

Mother	Living	Dead	Date	Age	Why
Father	Living	Dead	Date	Age	Why

Siblings:

How Many Siblings Do You Have Sisters: Brothers:

	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why

Family History: Specify Which Member of Your Family (Parents / Siblings / Grandparents)

	When	Who		When	Who
Abuse			Heart Disease		
AIDS/HIV			Hepatitis		
Alcoholism			Liver Disease		
Allergies			Herpes		
Arthritis			High Cholesterol		
Asthma			High Blood Pressure		
Bleeding Disorders			Kidney Disease		
Cancer			Osteoporosis		
Depression			Psychiatric Care		
Diabetes			Recreational Drugs		
Epilepsy (Seizures)			STD		
Glaucoma			Suicide Attempt		
Goiter			Other		

Date:

Nutritional Information

Name:

What Are Your Favorite Foods and how often you eat them?

What Foods If Any Do You Crave:

What Foods Do You Avoid and Why:

How Many Meals Do You Eat: Week Days Weekends

Do You Eat: Between Meals Bedtime During The Night

What Do You Snack On & How Often:

Where Is Your Daily Food Prepared: Home % Restaurant % Fast Food % Other %

If Other Explain:

How Is Your Food Prepared At Home (ie: Bake, Boil, Broil, Fry, etc):

What Type Of Ingredients Do You Use (ie: Fresh, Frozen, Canned, Prepared, etc):

What Do You Eat When You Are Out:

What Do You Drink With Your Meals:

What Do You Drink During The Day: (Include How Much)

What Kind Of Water Do You Cook In: Tap Spring Filtered Distilled

What Kind Of Water Do You Drink: Tap Spring Filtered Distilled

Do You Use Artificial Sweeteners: Yes No What Kind:

Date:

Nutritional Information

Name:

Are You Now or Have You Ever Been On Any Diets: Yes No

If Yes What Type Of Diet(s):

Low Carb: High Protein: Low Fat:

High Fiber: Liquid (ie slimfast): Low Salt:

Diabetic: Low Cholesterol: Vegetarian:

Other:

Food Pyramid (Specify What Version): Other:

Weight Loss or Gain as a result:

How Is Your Appetite: Normal Excessive Diminished None Varies (Please Explain)

Have You Ever Fasted: Yes No How Long?

What Kind of Fast Did You Do?

Have You Ever Been on A Detoxification Program: How Long?

What Detox Program Did You Follow?

Height: Current Weight:

Previous Height: Height Loss/Gained in Last Year

Most You've Weighed: Weight Loss/Gained in Last 6 Months:

What's Your Goal: Gain Lose How Much? Remain Unchanged

Do You Exercise? How Often?

Type of Exercise:

Any Problems While Exercising:

Little or No Sweating During Exercise Profuse Sweating During Exercise

Patient or Patient Representative Signature Date