NEW CLIENT INFORMATION

Today's Date___________

PERSONAL INFORMATION

Name:___________________________________Age:_____ Date of Birth:__________________

Marital Status S__ M__ D__ W__ Other___________________

Mailing Address:___________________________ City: _______________________ State: ____ Zip: _________

Home Phone: (_____) ______________ Cell Phone: (______) ___________ E-mail:______________________________

Occupation: _________________________ Employer/School: _____________________________________

Work Phone: (______) _____________ Work Status: Full-Time __ Part-Time__ Seasonal__ Other __________

In case of an Emergency – Contact: _____________________________Relationship: ___________________

Home Phone: (______) ___________________ Cell Phone: (______) _____________________

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us? ____

General Information:

Height:___________ Weight: _________ Recent Weight Loss __ / Gain __? Amount? _______ lbs.

Reason/method for weight loss/gain: _____________________ Number of Bowel Movements/Day: ________

Difficulty Falling asleep? Y__ N__ Difficulty Staying Asleep Y__ N__ Tired after full night's sleep? Y__ N__

Lightheaded/Irritable When Hungry? Y__ N__ Crave sugar/salt? Y__ N__ Fatigue after meals? Y__ N__

Need coffee/sweets 3-4pm? Y__ N__ Do you eat Breakfast? Y__ N__ Do you eat snacks b/t meals Y__ N__

Usual Breakfast:____
Usual Lunch: ____
Usual Dinner:____
Usual Snack:____

Do you have any dietary restrictions? Food allergies? Y__ N__ Please explain: (Paleo, vegetarian, gluten, dairy intolerance, Kosher, etc.)____
____

CLIENT NAME: ___________________________

Women Only:

Is there any chance you might be pregnant? Y__ N__ Date of last Menstrual cycle: _______________

Are you experiencing perimenopause? Y__ N__ Reached Menopause? Y__ N__

Are you experiencing symptoms? Y__ N__ Comments: ____

Do you currently, or have you used any of the following? (Please circle all that apply): Birth Control Pills, Hormone Replacement Therapy, Hormone IUD, Copper IUD, Contraceptive Shot (ex. Depo), Vaginal Ring, Contraceptive Patch, Emergency Contraceptive Length of use of each type? ___________________________

Have you ever had an abnormal PAP? Y__ N__Comments:____

Age of Menarche (periods began): ______________ Age of Children (if any): ________________________

# of pregnancies: ______________ # of birth children: ________________ # of C-Sections:_________

Health History:

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Depression/Anxiety
___Diabetes
___Eczema/Psoriasis
___Epilepsy

___Goiter
___Gout
___Heart disease
___Hepatitis A/B/C
___Herpes
___High Blood Pressure
___ HIV/AIDS
___ Pleurisy

___ Pneumonia
___ Stroke
___ Tumor(s)
___ Ulcer(s)

Other: ____

Do you wear corrective lenses? Y__ N__ Date of Last check-up/prescription change? ____________________

Date of most recent physical/annual exam: ____________________ Did you have blood-work done? Y__N__

Results/Concerns:____

____

____

Serious Illnesses/Hospitalizations/Surgeries: *Please detail (year, reason, outcome)*___________

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WORK ACTIVITY:

__Heavy Labor __Light Labor __Mostly Sitting __Mostly Standing __Walking/Moving __Driving

STRESS LEVEL:

__ Very High __ High __Medium __Low

Have you traveled in the last twelve months? Y__ N__

If yes: Where (especially internationally) ____

____

If you have any concerns or questions you would like to note here, or issues you think might be related to your condition please do not hesitate to discuss any matter with Dr. Rinehart at any time!

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______________________________ ______________________________

Participant Name (Printed) *Participant Signature*

____

Date

______________________________ ______________________________

Parent and/or Guardian Printed *Parent and/or Guardian Signature*

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