Potential New Client Application and Case History

Name:______________________________ Age_____ Sex: M F DOB___________ Today's Date___________

Address: ______________________________ City ________________________ State______ Zip___________

Home Phone:_______________________________ Work Phone ______________________________________

Cell Phone _________________________________ Cell Phone Carrier _________________________________
Contact preference: Phone: ☐Home ☐Work ☐Cell OR ☐Text Message
May we leave a voice mail? ☐Yes ☐No May we confirm appointments by text message? ☐Yes ☐No

Email address:_______________________________________ Receive e-health info? ☐ Yes ☐No

Employer:_______________________________ Occupation: ____
If retired, former occupation/employer: _________________________Were you exposed to chemicals in your occupation? ☐ Yes ☐No

Marital Status: ☐S ☐M ☐W ☐D ☐Engaged Spouse/Fiancé name:__________________________
Did your spouse or significant other attend session today? ☐Yes ☐No

How did you hear about us? ____

PRESENT COMPLAINTS

1. Main Problem(s):____

2. In spite of the fact that you are not a doctor, you are in fact a person who knows more about your condition than anyone else. In your own words and in your own opinion, what do you think the real problem is?

____

3. What are the three things your health problems have caused you to miss the most?

   a. _____________________________ b. ______________________________ c. _________________________

4. If you cannot find a solution to your problem, what do you think will happen? ___________________

____

5. Due to your condition, have you lost time from (describe how much time and what tasks have been limited)?

Work: ☐Yes ☐No Describe:____
Family: ☐Yes ☐No Describe:____
Leisure Activities: ☐Yes ☐No Describe:____

6. On a scale of (1=least) **1-10** (10=best), how important is your health?____________________(1-10)

Patient's Signature: ____