ALTERNATIVE HEALTH CENTER

WHERE EACH VISIT IS SPECIAL

Patient Information Date_____

What is your name? _____

Birthday _(month)___/ (day)____/(year)_____ Age_____

What do you prefer to be called? _____ Spouse's name? _____

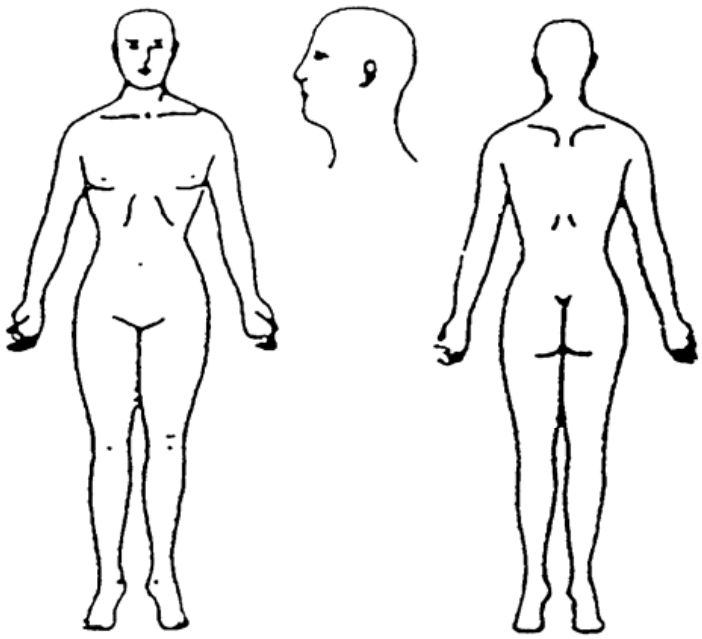
What are the names and ages of your children? _____

How did you hear about our office? _____

Home Phone _____ Cell _____

E-mail address_____

1) Circle the areas on the picture that are bothering you.



2) Explain in detail what is the reason for your coming to this office? (symptoms and sickness)

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_____

3) How are your current problems affecting your life? What can't you do that you would like to?

_____

_____

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4) How do you think you will be in 12 months if you don't do anything about your problem?

_____

_____

5) Is your problem the result of an accident?

_____

_____

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