

Terra Wellness

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Home Phone (____) ____ - _____ Work Phone (____) ____ - _____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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Your overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): _____

Previous treatments for this complaint _____

Other complaints or problems: _____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Outcome: _____

Medical history: (Do you have or have you ever had): ___ Arthritis ___ Asthma

___ Anemia ___ Heart trouble ___ Cancer ___ Diabetes ___ Epilepsy ___ Stroke

___ Kidney/ Bladder trouble ___ Gallstones ___ Ulcers ___ High blood pressure

___ Chronic fatigue ___ Hepatitis ___ Jaundice ___ Sudden weight loss

___ Sudden weight gain ___ Head injury ___ Other:

Major surgeries + dates: _____

Fractures / traumas: _____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

PLEASE MARK SIGNS AND SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST 3 – 6 MONTHS.

Energy level: Highest (time of day) _____ Lowest (time of day) _____

Stress: ___ Low ___ Moderate ___ Severe What triggers it?

Musculo-skeletal (muscle and joint) pain:

___ Pain ___ Weakness ___ Swelling ___ Stiffness ___ Leg cramps ___ Muscle spasm
___ Loss of feeling/numbness ___ Tingling sensation ___ Other:

Where:

Dates of onset (first occurrence):

Pain Level: ___ Minimal ___ Moderate ___ Severe Where:

Rate the pain on a scale from: (least) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (most)

Pain feels like: ___ Stabbing ___ Dull ache ___ Nagging ___ Like a tooth ache
___ Burning ___ Sharp

How long have you had this condition?

Have you had this in the past: ___ Yes ___ No When:

What makes it worse?

What makes it better?

Is your condition getting: ___ Worse ___ The Same ___ Comes and Goes

Neurological:

___ Nervousness ___ Depressed ___ Easily angered ___ Easily irritated ___ Frequent crying

___ Worry / anxiety ___ Mood swings ___ Poor memory ___ Confusion ___ Poor concentration ___ Suicidal

___ Tremors ___ Poor coordination ___ Feeling weak / shaky ___ Seizures

___ Neuralgia ___ Shingles ___ Other:

Nutrition: List some of your favorite foods:

Do you: ___ Skip breakfast ___ Eat snacks ___ Eat a hearty breakfast
How many meals a day? When is your biggest meal?
Do you eat when you are worried or upset? How often does that occur?
How many glasses of water do you drink a day? ___ Bottled ___ Filtered

DO YOU:

Eat raw fruits or vegetables at least x2 / day?
Are you ___ vegan ___ vegetarian ___ carnivore?
Eat frequently between meals? Eat when you are not hungry?
Chew your food thoroughly? Eat when you feel full?
Occasionally go on a crash diet? Eat fast?
Do you drink: ___ Milk ___ Juice ___ Sodas ___ Diet sodas
___ Alcohol ___ Social ___ Daily How many?
___ Black tea How many cups / day? ___ Coffee How many cups / day?

Please list any known allergies you have: _____

Please list any major losses that have occurred to you in your lifetime to the best of your recollection (with approx. dates). Starting from the earliest time you can remember up until now will help give me insight into the unique way that your body has managed stress, challenges and transitions in your life. _____

Comments or questions? _____

Is there anything I can do to assist your well being today beyond what was already listed?

SIGNED: _____ DATE _____