Date:___________________

Patient Name: ___________________________**Preferred/Nickname:**_________________

Street Address:____ **Unit #:**______________

City: ____________________________________ **State:**________ **Zip:** ________________

Check Appropriate Choice: Minor __ Single __ Married __ Spouse Name: _____________

Date of Birth: _____________ **Email Address:** _____________________________________

Cell Phone: (   ) ____________________ **Cell Carrier:**_____________________________

Are you a Student?: Yes___ No___ **Name of School**: ____________________ FT__ PT__

Do you have any children?: ____

Employer:_________________ **Favorite Activities/Hobbies:**__________________________

How did you hear about us? Who may we thank?: ______________________________

Emergency Contact: _____________________________ **Phone #:** (   ) ______________

Regular Physician:___________________________ **Clinic Name:** ____________________

Major Problem Area: ____

Autonomic Side Effects (circle all that apply):

Ringing/Pressure in Ears, Vertigo, Spotted or Blurry Vision, Asthma, Seasonal Allergies,

Salivation, Perspiration, Rashes or Acne, Change in Hair/Nails, Circulation, Heartburn

Reproductive, Frequent Urination, Diabetes, Anxiety, Diarrhea/Constipation,

Medications and/or Supplements: ____

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