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## Holistic Medicine Patient Questionnaire

Referred By: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

### Reason for today's visit:

\_\_\_\_\_ Anxiety \_\_\_\_\_ Control of painful periods \_\_\_\_\_ Menopausal symptoms

\_\_\_\_\_ Depression \_\_\_\_\_ Hypertension \_\_\_\_\_ Pain \_\_\_\_\_ Headaches \_\_\_\_\_ Stress

WT: \_\_\_\_\_ LBS LMP: \_\_\_\_\_ PRE-MENOPAUSAL \_\_\_\_\_ POST MENOPAUSE \_\_\_\_\_ HYST \_\_\_\_\_

### Birth Control Method:

NONE \_\_\_\_\_ IUD \_\_\_\_\_ CONDOMS \_\_\_\_\_ BCP \_\_\_\_\_ TUBAL LIGATION \_\_\_\_\_ ESSURE \_\_\_\_\_

DEPOSHOT \_\_\_\_\_ IMPLANON \_\_\_\_\_ PARTNER/VASECTOMY \_\_\_\_\_

Medications: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### ALTERNATIVE THERAPIES YOU HAVE PREVIOUSLY EXPERIENCED: (CHECK ALL THAT APPLY)

\_\_\_\_\_ Traditional Chinese Medicine \_\_\_\_\_ Homeopathy \_\_\_\_\_ Acupuncture \_\_\_\_\_ Medication

\_\_\_\_\_ Relaxation Techniques \_\_\_\_\_ Hydrotherapy \_\_\_\_\_ Guided Imagery \_\_\_\_\_ Biofeedback

\_\_\_\_\_ Chiropractic \_\_\_\_\_ Naturopathy \_\_\_\_\_ Massage Therapy \_\_\_\_\_ Reflexology \_\_\_\_\_ Reiki

\_\_\_\_\_ Therapeutic Touch \_\_\_\_\_ Bio-Electro Magnetic Therapy

I have read the description of the services that I will be receiving today. I understand that these services are not intended to treat or diagnose; it is an adjunctive therapy. By signing below I agree to obtain these services today.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_