

Welcome to Equinox Health and Healing

Please complete the questions below so that we may serve you better.
We respect the confidential nature of this information, and will not release it without your permission, or as required by law. Thank you.

Date: _____

Initial Health Information

Please print clearly

Name (Last, First, MI) _____ SS#: _____

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

Primary Care Physician: _____ Phone: _____ Cell Phone _____

Referred By: _____ Email: _____

Best means of contacting you: Phone Cell Phone Email

How did you hear about Equinox? _____

Do you understand your patient rights? Yes No

History of Present Illness:

What do you hope to achieve from your visit to Equinox? _____

Are you experiencing a present health problem? (Please list) _____

When did it begin? _____

How frequently do you experience symptoms? Infrequently Intermittently Constantly

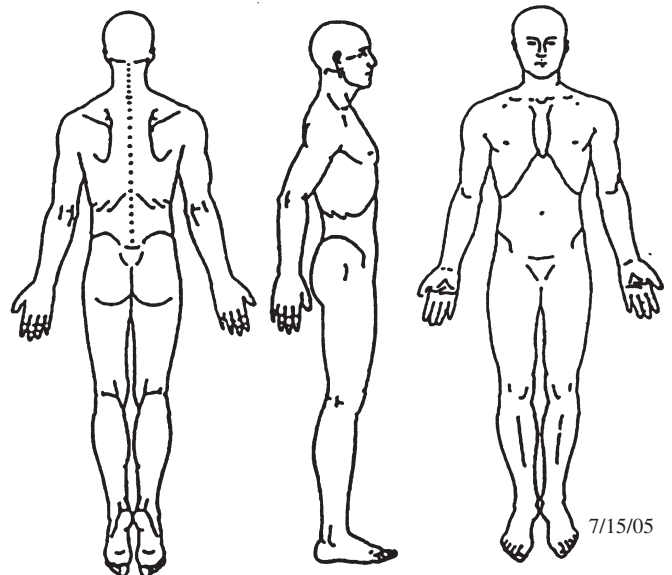
How long do your symptoms last? _____

How would you describe the pain? Burning Numbness Aching Stabbing Other _____

What, if anything, makes it better? _____

What, if anything, makes it worse? _____

Please use this scale to indicate your current level of discomfort / pain, and indicate region.



Past Medical History

Please check any of the following conditions you have now or have had in the past:

Now	Past		Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Motion Sickness
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Panic Attacks/Fears	<input type="checkbox"/>	<input type="checkbox"/>	Eye/Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Muscle, Bone, Joint Injury
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fractures, Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Neckaches
<input type="checkbox"/>	<input type="checkbox"/>	Backaches	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological/Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder/clots	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/any implants
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Concussion/Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Immune Sytem Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Digestion/Intestinal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus
<input type="checkbox"/>	<input type="checkbox"/>	Ear/Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins

Please list any Medications/Vitamins/Supplements/Herbal Products that you are currently taking: _____

Allergies to medications? _____

Allergies to Latex? Yes No

Other Allergies/Sensitivities (food, environmental, skin) _____

Are you left handed Right handed

Last Tetanus immunization update? _____ Influenza or flu vaccine? _____

Pneumonia vaccine? _____ Other recent vaccine? _____

Please list previous Traumas, Surgeries, Illnesses/Hospitalizations:

Reason:

Date:

Have you had any prior: (please list reason, approximate date, and outcome)

Physical/Occupational Therapy: _____

Massage Therapy: _____

Acupuncture: _____

Chiropractic: _____

Nutritional Consultation: _____

Counseling: _____

Reproductive History (For Women Only):

Age Menstruation began: _____ Length of usual menstrual cycle: _____
 Number of pregnancies: _____ Number of miscarriages: _____
 Do you have irregular menstruation? _____ If yes, which type? early / late / spotting / irregular cycle
 Are you pregnant now? Yes No If yes, how many weeks? _____
 Have you reached menopause? Yes No If yes, at what age? _____
 Have you had a hysterectomy? Yes No If yes, at what age? _____
 Have you had problems with infertility? Yes No Have you had toxemia? Yes No
 Have you had problems with fibroids? Yes No

Family History:

Age (if deceased, please list cause of death and age)

Medical and Psychological Illnesses

Mother: _____
 Father: _____
 Brother(s): _____
 Sister(s): _____
 Partner/Spouse: _____
 Children: _____

Social History

Is English your primary language? Yes No If no, what is? _____
 Highest level of education attained: _____
 Do you exercise? Yes No If yes, what type and how often? _____
 How do you relax? _____
 What brings you joy? _____
 Do you meditate or practice a relaxation technique? _____
 Describe any current emotional or life stress: _____

 Please list your hobbies: _____
 Are there any religious, cultural or spiritual needs pertinent to your treatment? Yes No
 If yes, please describe: _____
 How do you learn best? seeing hearing doing reading
 Are you interested in learning more about your health condition? Yes No
 Do you use an assistive device, including wheelchair, splint or cane? _____
 Do you need assistance with transportation? Yes No
 Do you need assistance with daily activities? Yes No
 If yes, please describe: _____
 Do you live alone? Yes No If no, with whom do you live? _____
 Have you smoked, or do you smoke tobacco of any kind? Yes No
 How much? _____ How long? _____ Have you quit? Yes No
 If not, would you like assistance in quitting? Yes No
 Do you chew tobacco? Yes No
 How many drinks of alcohol do you average daily? _____ Weekly? _____
 Do you use recreational drugs, i.e. marijuana, cocaine, stimulants? Yes No
 In the last year, have you ever drunk alcohol or used drugs more than you meant to? Yes No
 In the last year, have you ever felt you wanted, or needed, to cut down on drinking or drug use? Yes No

