

Medical History Form

** indicates a required field*

Primary Reason for Visit

*** What is your main reason(s) for coming to see us?**

- ☐ Pain
- ☐ Neurological symptoms
- ☐ Hormonal / metabolic concerns
- ☐ Mental clarity / brain health
- ☐ Energy / fatigue
- ☐ Stress / burnout
- ☐ Performance optimization
- ☐ Preventative / wellness care
- ☐ Other

Please describe your primary concern in your own words:



Medical History

*** When did your current symptoms begin?**

- ☐ Less than 1 month
- ☐ 1–3 months
- ☐ 3–6 months
- ☐ 6–12 months
- ☐ Over 1 year
- ☐ Not Sure
- ☐ Other

*** Have your symptoms:**

- ☐ Stayed the same
- ☐ Gradually worsened
- ☐ Improved
- ☐ Fluctuated

What makes your symptoms better?**What makes your symptoms worse?**

*** Have you ever been diagnosed with any of the following?**

- ☐ Neurological conditions
- ☐ Autoimmune disease
- ☐ Cardiovascular disease
- ☐ Diabetes / blood sugar issues
- ☐ Thyroid Disorder (High)
- ☐ Thyroid Disorder (Low)
- ☐ Hormonal imbalance
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Chronic pain
- ☐ Digestive disorders
- ☐ Sleep disorders
- ☐ Head injuries / concussions
- ☐ Other
- ☐ None

Have any immediate family members (parents, siblings, grandparents) been diagnosed with:

- ☐ Heart disease
- ☐ Stroke
- ☐ Neurological conditions
- ☐ Autoimmune disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Mental health disorders
- ☐ Other

Please list any medications you currently take:

Please list any supplements you currently take:

*** Have you ever had surgery?**

- ☐ Yes
- ☐ No
- ☐ If yes, please list type(s) & approximate date(s)

*** Do you have any implanted medical devices?**

- ☐ Pacemaker
- ☐ Neurostimulator
- ☐ Metal Implants
- ☐ Other
- ☐ None

*** Have you ever experienced trauma (physical or emotional) that you believe may still impact your health?**

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

If yes, is it anything you would like to share? COMPLETELY OPTIONAL!

Pain Assessment (If Applicable)

* Are you currently experiencing pain?

- ☐ Yes
- ☐ No

Location(s) of pain:

Pain Scale (0 = no pain, 10 = worst pain imaginable)

Is the pain:

- ☐ Sharp
- ☐ Dull
- ☐ Burning
- ☐ Aching
- ☐ Shooting
- ☐ Constant
- ☐ Intermittent

Occupation

* Current Occupation

* Typical work environment

- ☐ Desk-based
- ☐ Physical labor
- ☐ Mixed
- ☐ Shift work / irregular hours

Stress

* On a scale of 1–10, how would you rate your current stress level?

* Major sources of stress (check all that apply)

- ☐ Work
- ☐ Family
- ☐ Finances
- ☐ Health
- ☐ Sleep
- ☐ Emotional / mental health
- ☐ Other

Diet

*** How would you describe your current diet?**

- ☐ Very poor
- ☐ Poor
- ☐ Average
- ☐ Good
- ☐ Excellent

Do you follow any specific dietary approach?

- ☐ None
- ☐ Gluten-free
- ☐ Dairy-free
- ☐ Keto
- ☐ Paleo
- ☐ Plant-based
- ☐ Kosher
- ☐ Other

Are you willing to make dietary changes if recommended?

- ☐ Not at all
- ☐ Somewhat
- ☐ Very willing

Lifestyle**Do you smoke or use nicotine products?**

- ☐ No
- ☐ Yes

Do you drink alcohol?

- ☐ No
- ☐ Yes

Do you use recreational drugs?

- ☐ No
- ☐ Yes

Sleep

* Average hours of sleep per night?

* Do you wake up feeling rested?

- ☐ Never
- ☐ Occasionally
- ☐ Most of the time
- ☐ Always

Do you experience:

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Night sweats
- ☐ Night terrors

Previous Experience

Have you ever tried alternative or integrative medical approaches?

- ☐ Chiropractic care
- ☐ Acupuncture
- ☐ Functional medicine
- ☐ Neurofeedback
- ☐ Biofeedback / Frequency medicine
- ☐ PEMF
- ☐ IV Therapy
- ☐ Supplements / herbal medicine
- ☐ Breathwork / meditation
- ☐ Other

How was your experience? (Good / Bad ?)

*** What are you hoping we can help you with specifically?**

Are you open to a multi-modal, root-cause-based approach to care?

- ☐ Yes
- ☐ No
- ☐ Unsure

Last chance... anything else you feel is important for us to know?

*** How did you hear about us?**

- ☐ Referral
- ☐ Google / online search
- ☐ Social Media
- ☐ Podcast / media appearance
- ☐ Event / seminar
- ☐ Other