Adult Patient Information *Thrive MD Las Cruces*

PERSONAL INFORMATION

Name: _____
Nickname/preferred name: _____
Address: _____
_____
Home Phone: _____ **Alternate Phone:** _____
Email: _____
Date of Birth: _____ **Sex:** _____
Married Status: ☐ Married/Partner ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Occupation: _____ **Employer:** _____
Spiritual practice, if any: _____

EMERGENCY CONTACT

Name: _____
Address: _____
_____
Home Phone: _____ **Alternate Phone:** _____
Relationship: _____

MEDICAL HISTORY

Do you currently have a medical doctor? ☐ No ☐ Yes. Doctor's name:
_____
Are you currently seeing a chiropractor, acupuncturist, counselor, naturopath or any other health care professional? If so, please list: _____
_____
_____

Allergies

History of allergies or reactions? ☐ No ☐ Yes (please list and include your reaction)
Medications: _____
Environmental: _____
Foods: _____ Other:
_____

How did you hear about Thrive MD Las Cruces?

☐ Friend
☐ Internet
☐ Newspaper
☐ Referral: _____
☐ Other: _____

Current Health Concerns in order of importance

1. _____ 3. _____
2. _____ 4. _____

List the prescribed medications, non-prescription medications currently taking with dosage:

_____
_____
_____
_____

List the herbals, vitamins, and minerals you are currently taking currently taking with dosage:

_____
_____
_____
_____

Please list any medications you have been prescribed, but are not taking:

_____

Please list any major illnesses, hospitalizations, surgeries (date and brief description):

_____
_____
_____ _____

PERSONAL AND FAMILY HISTORY

Please indicate if you or a family member (specify relationship) has experienced the following health complaints

__ Unknown/Adopted

AIDS/ HIV:	High Blood Pressure:
Addictions:	High Cholesterol:
Allergies:	Migraines:
Anxiety/Depression:	Obesity:
Anemia:	Sexual Abuse:
Arthritis:	Seizures:
Asthma:	Skin Disorders:
Cancer:	Thyroid Disorder:
Heart Disease:	

Review of Symptoms

Circle Yes if experienced within the last 2 months

Constitutional		
Recent Weight Change	Yes	No
Fatigue	Yes	No
Night sweats	Yes	No
Ears/Nose/Throat/Mouth		
Hearing loss/Ringing	Yes	No
Sinus congestion/pain	Yes	No
Sore throat/Voice change	Yes	No
Post-nasal drip	Yes	No
Eyes		
Wears Contacts/Glasses	Yes	No
Blurred/Double vision	Yes	No
Eye disease/injury	Yes	No
Eye Pain	Yes	No
Cardiovascular		
Chest pain	Yes	No
Palpitations	Yes	No
Dizziness/Lightheadness	Yes	No
Heart Problems	Yes	No
Respiratory		
Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/Asthma	Yes	No
Sleep Apnea	Yes	No
Musculoskeletal		
Joint pain/Stiffness	Yes	No
Muscle cramps/pain	Yes	No
Joint swelling	Yes	No
Endocrine		
Excessive thirst/hunger	Yes	No
Hair loss/ Unusual growth	Yes	No
Cold hands/feet	Yes	No
Hormone imbalance	Yes	No
Neurological		
Frequent headaches	Yes	No
Tremors/Paralysis	Yes	No
Seizures	Yes	No
Numbness/Tingling	Yes	No
Skin		
Rashes/Itching	Yes	No
Discolored skin	Yes	No
Dry/Peeling skin	Yes	No
Excessive sweating	Yes	No
Urinary		
Blood in urine	Yes	No
Pain/burning with urination	Yes	No
Recurrent bladder infections	Yes	No
Difficulty urinating	Yes	No
Psychiatric		
Depression	Yes	No
Anxiety/Panic attacks	Yes	No
Confusion/Memory loss	Yes	No
Insomnia	Yes	No
Suicidal ideation	Yes	No
Female/Male Issues		
Sexual problems	Yes	No
Infertility	Yes	No
Testicular/Ovarian pain	Yes	No
Menstrual problems	Yes	No
Breast issues (lumps, pain, etc)	Yes	No
Hematologic/Lymphatic		
Anemia	Yes	No
Easy to bruise	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No
Digestive Issues		
Indigestion/Belching/Reflux	Yes	No
Constipation/Diarrhea	Yes	No
Abdominal pain	Yes	No
Nausea/Vomiting	Yes	No
Gas/Bloating	Yes	No
Blood in stool	Yes	No

Hemorrhoids	Yes	No

Women:
Start of first period: _____ Last menses start date: _____
Cycles: ☐ Regular ☐ Irregular. Average Cycle length: _____
Premenstrual complaints? ☐ Yes ☐ No. If yes, list: _____
Are you planning to conceive now or in the near future? ☐ Yes ☐ No

LIFESTYLE HISTORY

Stressors: Rate level of stress, (10 = high stress, 1 = low stress): _____
Top stressor currently or in recent past, if any: _____
Exercise:
Do you exercise regularly? ☐ Yes ☐ No
Regimen: _____
Frequency/Duration: _____How long on this program?_____
Diet:
Do you eat breakfast? ☐ Yes ☐ No. Time: _____
Describe typical meal: _____
Do you eat lunch? ☐ Yes ☐ No. Time: _____
Describe typical meal: _____
Do you eat dinner? ☐ Yes ☐ No. Time: _____
Describe typical meal: _____
Do you snack? ☐ Yes ☐ No. Typical snacks:_____
What are your food cravings, or attractions? _____
Coffee: _____cups/day, Caffeinated Tea: _____cups/day, Water: _____glasses/day
Habits:
Do you smoke or chew (tobacco)? ☐ Yes ☐ No _____packs/day or amount/day
Do you drink alcoholic beverages? ☐ Yes ☐ No _____drinks per: day week month
Use recreational drugs? ☐ Yes ☐ No. If yes, which:
_____
Sexual habits:
Sexually active: ☐ Yes ☐ No. If yes, number of sexual partners: ☐ 1, ☐ 2, ☐ 3+
Contraception use: ☐ Yes ☐ No. If yes, which:
_____
Sleep:
Rate the quality of sleep (10 is great, 1 is poor): _____
Average hours of sleep per week: _____, weekend: _____

Goals/Expectations: _____
_____
_____