Ron Violet BCTN•ACN•LMT
Evoking Body-Mind Synergy
6009 RITTIMAN PLAZA ❁ SAN ANTONIO, TX 78218 ❁ 210-822-3570 PHONE

PLEASE PRINT

PERSONAL INFORMATION

NAME_____ DATE_____

ADDRESS_____CITY_____ STATE_____ZIP_____

PHONE_____SOC. SEC. NO._____ DATE OF BIRTH_____

MARITAL STATUS_____SEX_____AGE_____NUMBER OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

NAME OF SPOUSE_____ SPOUSE'S OCCUPATION_____

EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

REFERRED BY_____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash or check basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.
Date_____ Patient's Signature_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN?_____

_____

TODAYS CONDITION STARTED WHEN?_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION?_____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

Habits

- ❑ Alcohol: Type_____
  Amount_____
  Diet: Salt intake_____
  Fat intake_____
  Other_____
- ❑ Sleep: Difficulty falling asleep_____
  Continuity disturbances_____
  Early morning awakenings___
  Daytime drowsiness_____
  Other_____
- ❑ Smoking: Packs daily_____
  How long_____
  Interested in stopping?_____
- ❑ Exercise routine:____
  _____
  _____
- ❑ Caffeine: Coffee, cups daily_____
  Other_____

MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

- ❑ Ringing In Ear_____
- ❑ Ear Infections - *Frequent* _____
- ❑ Dizziness/Fainting _____
- ❑ Failing Vision _____
- ❑ Eye Infections _____
- ❑ Nose Bleeds_____
- ❑ Sinus Trouble _____
- ❑ Sore Throats - *Frequent* _____
- ❑ Hayfever/Allergies _____
- ❑ Pneumonia _____
- ❑ Bronchitis/Chronic Cough_____
- ❑ Asthma/Wheezing _____
- ❑ Chest Pain _____
- ❑ High Blood Pressure _____
- ❑ Heart Murmur _____
- ❑ Swollen Ankles _____
- ❑ Leg Pain - *Walking*_____
- ❑ Varicose Veins/Phlebitis _____
- ❑ Loss of Appetite _____
- ❑ Difficulty Swallowing _____
- ❑ Indigestion or Heartburn _____
- ❑ Persistent Nausea/Vomiting _____
- ❑ Peptic Ulcers _____
- ❑ Abdominal Pain - *Chronic*_____
- ❑ Gall Bladder Trouble _____
- ❑ jaundice/Hepatitis _____
- ❑ Change in Bowel Habits _____
- ❑ Diarrhea ❑ Constipation _____
- ❑ Diverticulosis ❑ Crohn's/Colitis ____
- ❑ Bloody or Tarry Stools _____
- ❑ Hemorrhoids _____
- ❑ Hernia _____
- ❑ Urine Infections - *Frequent* _____
- ❑ Blood In Urine _____
- Urination-❑ Overnight > than twice
  ❑ Painful ❑ Loss of Control
  ❑ Decrease in Force/Flow
- ❑ Kidney Stones _____
- ❑ Venereal Disease_____
- ❑ Urethral Discharge _____
- ❑ Chronic Fatigue _____
- ❑ Weight Loss - *Recent*_____
- ❑ Anemia ❑ Bruise Easily _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Thyroid Disease _____
- ❑ Convulsions/Seizures _____
- ❑ Stroke _____
- ❑ Tremor/Hands Shaking _____
- ❑ Muscle Weakness _____
- ❑ Numbness/Tingling Sensations _____
- ❑ Headaches - *Frequent* _____
- ❑ Arthritis/Rheumatism _____
- ❑ Osteoporosis _____
- ❑ Back Pain - *Recurrent* _____
- ❑ Bone Fracture/Joint injury _____
- ❑ Gout _____
- ❑ Foot Pain ❑ Cold Numb Feet _____
- ❑ Rashes ❑ Hives _____
- ❑ Psoriasis ❑ Eczema_____
- ❑ Nervousness ❑ Depression_____
- ❑ Memory Loss _____
- ❑ Moodiness - *Excessive* _____
- ❑ Phobias _____
- ❑ Mental Illness_____
- ❑ Lactose Intolerance _____
- ❑ Prostate Disease _____
- ❑ Sexual/Menstrual Dysfunction ____
- ❑ Frequent Infections _____
- ❑ Diphtheria _____
- ❑ Tetanus _____
- ❑ Chicken Pox ❑ Polio ❑ Mumps ❑
- Measles ❑ Rubella ❑ Rheumatic Fever
- ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
- ❑ Other _____
- ❑ Other _____

Females - *Please Complete*

- Pregnant? ❑ Yes ❑ No
- Planning Pregnancy? ❑ Yes ❑ No
- Menstrual Flow:
- ❑ Regular ❑ Irregular ❑ Pain/Cramps
- ____Days of Flow ____Length of Cycle
- Date-1st day of last period_____
- ❑ Pain/Bleeding during or after sex
- **Number of:**
- ____Pregnancies ____Abortions
- ____Miscarriages ____Live Births
- Birth Control Method_____
- B.C. Pill (Name) _____
- ❑ Flushing/Menopause
- Date of Last PAP Test _____
- ❑ Normal ❑ Abnormal
- Date of Last Mammogram
- ❑ Normal ❑ Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE	_____
	_____	_____	_____	GLAUCOMA	_____
	_____	_____	_____	EPILEPSY	_____
SPOUSE				RHEUMATOID ARTHRITIS	
CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD PRESSURE	_____
				HEART DISEASE	
				BACK PROBLEMS	