Patient Name: _____

DOB: _____ MRN: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Email address: _____

Phone Number: (Home) _____ (Work) _____ (Cell) _____

Preferred phone: _____ Best time to call you: ☐ Morning ☐ Afternoon ☐ Evening

CONTACT INFORMATION

Patients over 18 years old:

If you are not present to receive a telephone call, may we leave a detailed voicemail message? ☐ Yes ☐ No

May we leave a detailed message with someone else? ☐ Yes ☐ No

If yes, with whom and what is his/her relationship to you?

If patient is a Minor (<18 years old), please provide Parent's/Legal Guardian's information:

Parent/Legal Guardian #1's name: _____ Date of Birth: _____

Same contact information as patient? ☐ Yes ☐ No If no, please provide below:

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent/Legal Guardian #2's Name: _____ Date of Birth: _____

Same contact information as patient? ☐ Yes ☐ No If no, please provide below:

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Physician Name and Specialty: _____

Primary Care Physician's (PCP) name: _____

PCP Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax: _____

Other physicians followed on a regular basis:

Specialty: _____ Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax:_____

Specialty:_____ Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax:_____

Specialty: _____ Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax:_____

Specialty: _____ Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Fax:_____

PATIENT'S MEDICAL HISTORY

1. Has the patient already been diagnosed with a genetic condition? ☐ Yes ☐ No

   If yes, what specific condition? _____

   Name of physician who diagnosed the patient and type of physician? _____

   When was the patient diagnosed? _____

2. When did the patient's symptoms pertaining to this appointment first start, and what were those symptoms?

   _____

   _____

   _____

   _____

Patient Name: _____

DOB: _____ MRN: _____

3. What has been used to treat the patient's symptoms?

_____
_____
_____
_____

4. Has the patient ever had physical therapy? If so, for what? (If local, what facility?)

_____
_____
_____
_____

HOSPITALIZATIONS

DATE	REASON

SURGERIES

DATE	SURGEON/FACILITY	PROCEDURE	OUTCOME

MEDICAL DIAGNOSES (applicable to the visit)

DIAGNOSIS	CURRENT TREATMENT

GENETIC TESTING

Please list any genetic testing that the patient has had done along with the results.

_____
_____
_____
_____

Patient Name: _____

DOB: _____ MRN: _____

DIAGNOSTIC STUDIES/TESTS

Please provide information regarding any other diagnostic studies/tests.

STUDY	DATE OF STUDY	ABNORMALITIES/DIFFERENCES

KNOWN ALLERGIES

Please list allergen and corresponding reaction

ALLERGY	REACTION

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION	ROUTE (mouth, injection, eye drop, etc.)

Patient Name: _____

DOB: _____ MRN: _____

REVIEW OF SYSTEMS

Please indicate if the patient has had any of the following issues:

General Health

☐ Unexplained weight gain How much & over what period of time? _____

☐ Unexplained weight loss How much & over what period of time? _____

☐ Difficulty falling asleep Comments: _____

☐ Difficulty staying asleep Comments: _____

☐ Chronic fatigue Comments: _____

Skin/Hair

☐ Slow wound healing Comments: _____

☐ Easy bruising Comments: _____

☐ Skin fragility Comments: _____

☐ Other skin/hair problems Specify: _____

Head/Ears/Eyes/Nose/Teeth

☐ Ringing in the ears (tinnitus) Comments: _____

☐ Hearing problems Comments: _____

☐ Nearsightedness (myopia) Comments: _____

☐ Farsightedness (hyperopia) Comments: _____

☐ Other vision problems Comments:_____

☐ Wears glasses/contacts Comments: _____

☐ Narrow palate Comments: _____

☐ Braces/orthodontia Comments: _____

☐ Jaw pain/TMJ Comments: _____

Patient Name: _____

DOB: _____ MRN: _____

Respiratory

☐ Shortness of breath Explain: _____

☐ Difficulty breathing Explain: _____

☐ Asthma Exercise induced or allergy: _____

Cardiovascular

☐ Tachycardia Comments: _____

☐ Dizziness Comments: _____

☐ Fainting How often? _____

☐ Exercise intolerance Comments: _____

Gastrointestinal

☐ Hiatal hernia Comments: _____

☐ Reflux Comments: _____

☐ Constipation How often? _____

☐ Irritable bowel syndrome Comments: _____

☐ Gastroparesis Comments: _____

☐ Diverticulitis/diverticulosis Comments: _____

☐ Nausea How often? _____

☐ Abdominal Pain How often? _____

☐ Blood in stool How often? _____

Genitourinary

☐ Urinary incontinence How often? _____

☐ Bladder prolapse Comments: _____

☐ Endometriosis Comments: _____

Blood/Lymphatic

☐ Anemia Comments: _____

☐ Bleeding tendency Comments: _____

Patient Name: _____

DOB: _____ MRN: _____

Musculoskeletal

☐ Hypermobility Comments: _____

☐ Joint dislocations Which joints? _____

☐ Joint subluxations (popping) Which joints? _____

☐ Joint pain Which joints? _____

☐ Joint swelling Which joints? _____

☐ Joint redness Which joints? _____

☐ Osteoarthritis Comments: _____

☐ Fibromyalgia Comments: _____

☐ Scoliosis Comments: _____

Neurological

☐ Migraine headaches How often? _____

☐ Non-migraine headaches How often? _____

Psychiatric

☐ Depression Comments: _____

☐ Anxiety Comments: _____

☐ ADD or ADHD Specify: _____

Signature of Patient/Parent/Legal Guardian Completing the Form: _____

Printed Name of Patient/Parent/Legal Guardian Completing the Form: _____

Relationship to Patient: _____ Date: _____