# Patient Information Form

Welcome! Thank you for allowing Dr. Buenz to assist you in your quest for wellness. Please complete this form as thoroughly as possible. If you have any questions, do not hesitate to ask for assistance. We will be happy to help.

**Patient Information: (please print)**

Date: _____

Name: _____ DOB: _____ Age: _____ Male / Female

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

Phone: (h) _____ (w) _____ (c) _____

Email address: _____ Marital Status: S M D W

Name of Spouse/Significant Other: _____ Children _____

If you are a minor, your parents' names: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you? _____

How did you hear about us? _____

Please list the Top 5 health issues that you would like to resolve and what you are currently doing for them (if anything):

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all medications you are currently taking (prescribed and over-the counter) and the condition for which it has been prescribed:

_____

_____

Please list all surgeries, hospitalizations, major illnesses, and accidents: _____

_____

Please list all nutritional supplements, homeopathic, or herbal remedies you are currently taking: _____

_____

Please list all other health providers you are currently seeing on a regular basis (include your medical doctor, chiropractor, massage therapist, energy workers, etc.): _____

_____

**Health History** *Circle all conditions that you have had in the past or is currently a concern:*

AIDS/HIV
ADD/ADHD
Alcoholism
Allergies shots
Anorexia
Appendicitis
Arthritis
Bleeding disorders
Breast lumps
Bronchitis
Cancer
Cataracts
Chemical dependency
Chicken pox
Chronic fatigue
Colitis/IBS
Constipation
Depression
Diabetes
Eating disorder
Emphysema
Endometriosis
Epilepsy
Fractures
Glaucoma
Goiter
Gout
Heart disease
Heavy metal toxicity
Hepatitis
Hernia
Herniated disc
Herpes
High cholesterol
Hypertension
Hypoglycemia
Infertility
Joint replacement
Kidney disease
Liver disease
Measles
Migraine headaches
Miscarriage
Mononucleosis
Multiple sclerosis
Mumps
Nursing (presently)
Osteoporosis
Pacemaker
Parasites
Parkinson's disease
Pinched nerve
Pneumonia
Pregnant (presently)
Prostate problems
Prosthesis
Psoriasis
Psychiatric care
Rheumatoid arthritis
Skin problems
Stroke
Thyroid problems
Tonsillitis
Tuberculosis
Tumors, growths
Ulcers
Vaginal infections
Venereal disease
Other _____
_____

**Daily Habits**

What type of exercise do you perform at least 3 days a week? _____

Describe a typical breakfast, lunch, dinner, and snack: _____

_____

_____

How much coffee, tea, soda do you consume on a daily basis? _____

How much alcohol do you consume on a weekly basis? _____

Do you smoke? No / Yes How much per day? _____ For how many years? _____

**Authorization**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. We are not responsible for aggravation of any pre-existing condition, which he patient has failed to fully disclose.

Name (please print): _____

Signature: _____ Date: _____

Parent or Guardian Authorizing treatment for minor or child: _____