HerbalQuest
WHERE NATURE & SCIENCE MEET.

Welcome to **HerbalQuest**

6825 Stewart Rd. Galveston 409.744.4372

Nutrition Patient Information Sheet

Welcome to our store. Please take a few moments to complete the following information. If you have questions regarding any of the questions contained within this document please ask our staff.

Date:_____

Personal Information

Last Name _____ First Name _____ M I ___

Address _____ apt number _____

City _____ State _____ Zip _____

Email address _____

Home Phone ___Wo_____ rk Phone _____

Cell Phone ___Ot_____ her contact number _____

Birthday _____ Sex : M F

Soc. Security # _____
***See Requirement section below.**

Whom may we thank for referring you ?
_____

Emergency Contact

In case of emergency we should contact this person.
Contact Name_____Relationship _____
Home Phone _____ Cell Phone _____

Reason for visit

Reason for Visit? _____ When did this first occur?_____
Are Symptoms getting progressively worse ? Yes No
Rate the severity of the problem **1** 2 3 4 5 6 7 8 9 **10** (Mild to Severe)
How often do you have the problem? _____
Does it interfere with sleep ☐ work ☐ daily life ☐ recreation ☐
Things that help condition? _____
Things that worsen condition?_____

Occupation/Type of work _____

Financial Section

☐ I will be paying for my services (Go to Back Side of Sheet) - Time of service discounts do not apply to Exams or X-rays.
☐ I have insurance that **might** cover some of the cost of my care.
Insurance company Name _____
Prim ary Insureds Name ___Relation_____ ship to patient _____
Other insurance ? _____ If Medicare —Primary or Secondary? _____
Please give your drivers license ☐ and insurance card ☐ to the staff. Copies of both documents will be made.
***All patients filing insurance must supply HerbalQuest with Social Security and Drivers License Information.**

Please Complete the back side of this form

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____
		Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Would you be interested in information about other services?

Chiropractic ☐ **Acupuncture** ☐ **Massage** ☐ **Animal Chiropractic** ☐