CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: _____/_____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name:_____Age:_____Date of Birth:_____

Address:_____/_____/_____/_____
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)_____/_(____)_____/_(____)_____
(home) (work) (cell phone orother)

E-mail address:_____Gender: female_____male _____

Are you (check one): Single____Married_____Other_____Partner's Name: _____

Occupation:_____(circle) Full time/ Part time /Student/ Retired

Employer / School: _____

Address:_____/_____/_____/_____
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact _____

(Name) (Relationship)

_(_____)_____(_____)_____
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
Is there any place you do **NOT** want me to leave a message? _____

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

By signing below, I verify that the above and below information is correct and true to the best of my knowledge.

Signature of Patient_____Today's Date _____

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: _____Date: _____

What are the concerns for which you are seeking care? (Primary concern first)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

Who is your primary care physician? _____
(Name) (Phone if known)

For what concern did you last receive health or medical care? _____

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? _____

_____

_____

Check each that you currently use:

__ Laxatives __Pain relievers __Antacids __Cortisone
__Antibiotics __Heart/Blood medication __Allergy Medication __Thyroid medication
__Sleeping pills __Anti-depressants __Birth Control Pills __Hormones

Do you have any known contagious diseases at this time? ◊ Yes ◊ No If yes, what?_____

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer_____ Diabetes_____ Epilepsy_____
Heart Disease _____ High Blood Pressure _____ Stroke_____
Anemia_____ Kidney Disease _____ Glaucoma_____
Allergies_____ Asthma_____ Mental Illness _____
Arthritis _____ Tuberculosis _____ Alzheimer's Dz_____

Name: _____ Date: _____

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever___Diphtheria____Rheumatic fever____Mumps____Measles___German measles ___

Have you had any immunizations? n Yes n No Negative Reactions? _____

Hospitalizations, Surgery, X-Ray and Special Studies

_____year:_____ _____year: _____

_____year:_____ _____year: _____

_____year:_____ _____year: _____

Allergies

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

_____

General

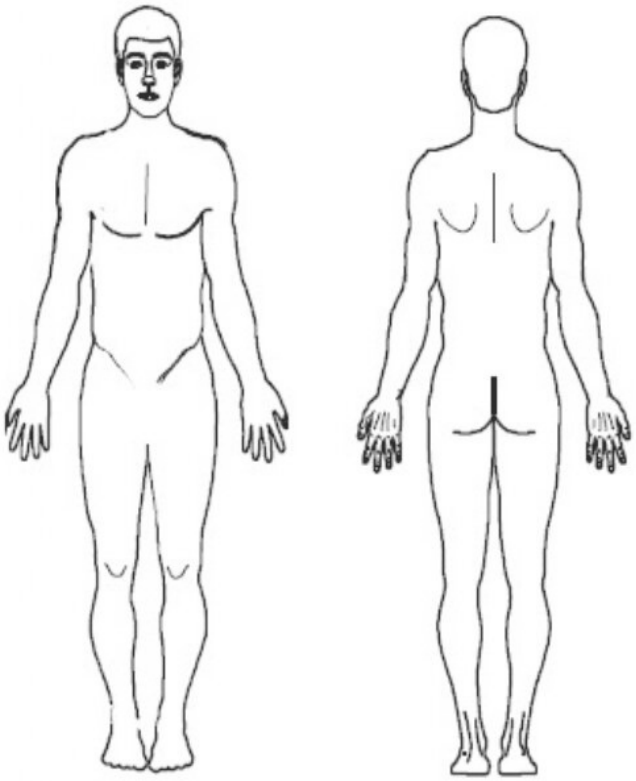
Weight _____lbs. Height_____ Weight 1 year ago_____lbs.

Maximum (non pregnant) Weight_____lbs. When _____

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Main interests and hobbies? _____
Exercise, what kind? _____
How often do you exercise? _____
__Y __ N Have a religious/spiritual practice
__Y __ N Average 6-8 hrs. of sleep
__Y __ N Have a supportive relationship
__Y __ N History of abuse
__Y __ N Major traumas
__Y __ N Use recreational drugs
__Y __ N Treated for drug dependence
__Y __ N Drink coffee
__Y __ N Drink black or green tea
__Y __ N Drink cola or other sodas
__Y __ N Add salt to your food
__Y __ N Eat refined sugar
__Y __ N Enjoy your work
__Y __ N Take vacations
__Y __ N Spend time outside
__Y __ N Watch TV? How much? _____
__Y __ N Read? How often? _____
__Y __ N Use alcoholic beverages
per week _____
__Y __ N Treated for alcoholism
__Y __ N Use tobacco currently
__Y __ N Used tobacco in the past
How many years? ___ Packs per day?___

Name:_____Date:_____

Context of Care Overview

Dr. Erin Shannon would like to welcome you to her practice. Please note that Dr. Shannon is a goal-oriented, interactive, solution focused therapist. Her therapeutic approach is to provide rapid symptom relief, continual support, and practical techniques to help clients effectively address both professional and personal life challenges. Below are a few questions that will assist Dr. Shannon in better understanding yourself and how she can best support your health.

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% **0 1 2 3 4 5 6 7 8 9 10** 100%

If you answered less than "10", what stands between your current commitment and 100%?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What do you love most about your life at this time?