East Gate Healing Arts Center
410 W. Fisher Avenue
Greensboro, NC 27401
336.370.4399

New Patient Information

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name _____ Sex M____ F____ Date_____Email_____

Address _____ City _____ State_____ Zip _____

Date of Birth _____ Place of birth _____ Age _____ Height _____ Weight_____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

_____ Single _____Married _____ Divorced _____Widowed _____ Living with _____

Education _____ Occupation _____

Referred by: _____

Reason for visiting our office _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep _____ Work _____ other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
seizures						
high blood pressure / heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorder						
muscular-skeletal disorder						

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PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner_____

Snacks_____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)

MEDICINES:
Prescription drugs you are currently taking: For what condition?

Over-the-counter medication you are currently taking: For what condition?

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

ANYTHING ELSE THAT WE NEED TO KNOW: