

PATIENT INFORMATION

Date _____

Personal Information

Last name _____

First name _____

Address _____

City _____

State _____ Zip _____

Birthdate _____

Sex Male Female

Marital status Single Married Divorced

Widowed Separated

Home phone _____

Business phone _____

Referred by _____

SS# _____

Religious preference _____

Responsible party _____

Name of spouse _____

Name of parents _____

(if a minor)

Medical Data

Are you allergic to medications (Penicillin, Vit. B-12, etc)? _____

Are you allergic to Procaine, Lidocaine, Xylocaine or Novocaine? _____

Do you have pets? _____ What kind? _____ Do they live in your home? _____

Habits

Do you drink coffee or regular tea? _____ How much? _____

Have you ever used alcohol? _____ How much and how often? _____

Do you smoke or did you ever use tobacco? _____ How much and for how long? _____

Have you ever used heroin, cocaine, LSD, PCP, marijuana, etc? Which ones and how frequently? _____

Have you ever used sleeping pills and/or pain pills? _____ How often? _____

Do you handle chemicals? _____ Which ones and to what extent? _____

Do you exercise regularly? _____ What type and how often? _____

Patient Information and Informed Consent

1. Acknowledgement – Notice to Medicare Subscribers

Please be advised that Christi Bonds, MD, does not accept assignment for Medicare. Therefore, please be advised that Medicare may not cover the expenses they feel are medically unnecessary. Medicare does not recognize medical acupuncture, electro-acupuncture, homeopathy, or nutritional counseling.

2. General Disclaimer regarding Non-toxic Therapy

Homeopathy, acupuncture, electro-acupuncture, Chinese herbal therapy, nutritional counseling, and bioenergetic medicine may not be recognized by some insurance companies, the FDA or mainstream medicine as reimbursable or acceptable. Nevertheless, in expressing my constitutional right of freedom of choice of medical care, I choose to be diagnosed and treated by Christi Bonds, MD.

RELEASE OF INFORMATION – I hereby authorize release of my medical information to the physician(s) I have been referred to by Christi Bonds, MD, or any person designated by me, and to my insurance carriers.

I have read, understood and agree to the above statements.

Signature of Patient (Parent/Guardian, if Minor)

Date

Energetic History

- A. Mark your favorite
- | | | |
|--|---|---|
| <p>I. FLAVOR</p> <p><input type="checkbox"/> Sour</p> <p><input type="checkbox"/> Bitter</p> <p><input type="checkbox"/> Sweet</p> <p><input type="checkbox"/> Spicy</p> <p><input type="checkbox"/> Salty</p> | <p>2. SEASON</p> <p><input type="checkbox"/> Spring</p> <p><input type="checkbox"/> Summer</p> <p><input type="checkbox"/> Indian Summer</p> <p><input type="checkbox"/> Fall/Autumn</p> <p><input type="checkbox"/> Winter</p> | <p>3. COLOR</p> <p><input type="checkbox"/> Blue</p> <p><input type="checkbox"/> Red</p> <p><input type="checkbox"/> Yellow</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black</p> |
|--|---|---|
- B. At what time of the day or night are your symptoms worse? _____ AM/PM
- C. Do you prefer to be inside? or to be outside?
- D. Do weather changes affect you? YES – How? _____ NO
- E. Do you sleep well? YES NO. If no, elaborate _____

- F. What is your energy level? worst 1 2 3 4 5 best
- G. What makes your symptoms better? _____
worse? _____
- H. What was the most significant medical or emotional occurrence in your life? _____

- I. On a scale of 1-10, what do you rate your present stress level? _____
What are the stressors in your life? _____
- J. What is your greatest fear? _____
- K. What really makes you happy? _____

Nutritional History

- A. What do you eat and drink for:
1. Breakfast _____
 2. Lunch _____
 3. Dinner _____
 4. Snacks _____
- B. What do you crave to eat? _____
- C. Do you have any food allergies? Yes – what are they? _____ No
- D. Do you have any digestive problems? _____
- E. Do you have regular bowel actions? _____
- F. Do you feel sleepy or tired after eating? _____
- G. Are you able to fast without symptoms? _____

Allergic History

Do you suffer from any of the following symptoms:

- | | | | | | |
|-----------------------------------|-------------------------------------|---|--|--|----------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> rashes | <input type="checkbox"/> hives | <input type="checkbox"/> hay fever | <input type="checkbox"/> arthritis | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> headache | <input type="checkbox"/> itchy eyes | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> sinusitis | <input type="checkbox"/> trouble with weight | |
| Trouble with | <input type="checkbox"/> perfumes | <input type="checkbox"/> gasoline fumes | <input type="checkbox"/> paints, chemicals | <input type="checkbox"/> smoke | |