Sarasota Healing Arts
Dr. Jessica Lipham, DOM, L.Ac. Office # 941-487-7311
1810 S. Tuttle Ave, Sarasota, FL 34239

New Client Information

Name:________________________________ Birthdate:__________ Today's date:__________

Address:____

Street City State Zip Code

Telephone: (H)_____________________(Cell)__________________ E-mail__________________

Marital Status: Single Married Divorced Separated Widowed Number of Children:_____

Occupation:_____________________ Referred by:________________________________

Major Complaints in order of importance to you

Complaint	Since	Cause

What medications are you currently taking?

Medication	Dose	Since	Adverse Effects

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What other treatment plans are you currently following?

Treatment	Since	Results

Which of the following conditions have you had? (please circle all that apply)

Abscesses	Cold sores	Genital herpes	Menstrual problems	Respiratory disease	Thyroid condition
Acne	Fatigue	Goiter	Miscarriage	Root canal	Tonsillitis
Alcoholism	Depression	Gout	Mononucleosis	Scarlet fever	Tropical disease
Allergies	Diabetes	Hay fever	Mood problems	Seizures	Tuberculosis
Anemia	Dizziness	Headaches	Mumps	Septicemia	Uterine fibroid
Asthma	Digestive problems	Heart disease	Parasites	Sexual abuse	Vaginitis
Athlete's foot	Ear infections	Hepatitis	Pelvic inflammatory disease	Sinusitis	Venereal warts
Back pain	Endometriosis	Infertility	Pleurisy	Skin disease	Vertigo
Cancer	Fibromyalgia	Ingrown toenails	Pneumonia	Sties	Warts
Canker sores	Flu	Joint pain	Psoriasis	Stroke	Whooping Cough
Chicken pox	Gallstones	Kidney Disease		Sun stroke	Worms
Other?					

Have you had any infectious disease from which you have never fully recovered?

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What operations have you had?

Operation	When	Complications
______________________________	___________________	________________________
______________________________	___________________	________________________

What major injuries have you had?

Injury	When	Long term effects
______________________________	___________________	_______________________
______________________________	___________________	_______________________
______________________________	___________________	_______________________

Age of first menses? ______ Number of pregnancies:________ Miscarriage/abortion:__________

Any adverse effects from vaccinations?____

Have you ever taken antibiotics for a prolonged period of time?_____________

For what condition?____

When was your last physical exam?_______________

Have you lost any weight lately?___________ How many pounds?___________

What exercise do you do?________________________________

How frequently do you exercise?____

How much of the following are you using: Tobacco__________________ Coffee_______________

Tea_________________ Alcohol_________________ Recreational drugs____________________

Which of the following have affected your relatives?
(Please circle all that apply)

Alcoholism	Depression	Heart disease	Pneumonia
Allergies	Diabetes	High blood pressure	Skin disease
Arthritis	Epilepsy	Mental illness	Syphilis
Asthma	Gonorrhea	Paralysis	Tuberculosis
Cancer	Gout		

Relative	Age if living	Age at death	Ailments
Mother	______	______	______
Father	______	______	______
Brother(s)	______	______	______
	______	______	______
Sister(s)	______	______	______
	______	______	______
Children	______	______	______
	______	______	______

Are you currently under the care of another health professional?

Specialty	For what condition(s)	Treatment
______	______	______
______	______	______
______	______	______
______	______	______

Do you have any other concerns or questions?

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