



**"The doctor of the future will give no medicine, but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease."
- Thomas Edison**

Patient Information

Thank you for choosing our practice for your needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Name: _____ Date: _____ SSN: _____

Address: _____ City _____ State _____

Sex: ___ Male ___ Female Date of Birth _____

Home Phone _____ Work _____ Cell _____

Do you prefer to be called at Home Work Cell Any

Are you: Minor Married Divorced Widowed Single Separated

Your Employer: _____ Occupation _____

Business Address: _____ City _____ State _____

Spouse's name (parent's name if minor): _____ Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you to us?: _____

Please read the following and sign below:

The CSA System provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the procedure is to disclose patterns of stress and to provide feedback to help in recommending a program to restore each system and meridian (energy pattern) to balance.

I understand that the Electrodermal Stress Analysis Survey does not provide a medical diagnosis, and that my testing technician may recommend further medical testing. If I suspect that I need further medical intervention, I will consult my medical physician.

I give my permission for the testing technician to evaluate me on the CSA System. I understand that by doing so *the testing technician is not becoming my primary care physician.*

I understand that the testing technician will give me information about myself based on the evaluation and will make recommendations to improve my health based on what is found. Any decision to follow through with the program will be my own decision, and I will not hold the testing technician or Holistic Health Options responsible.

Signature: _____ Date: _____

Technician Signature: _____ Date: _____

Symptoms:

Reason for your visit: _____

When did you first notice these symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem located? _____

Which activities are difficult to perform Sitting Standing Walking
 Bending Lying down Other _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burn- ing Tingling Cramps Stiffness Swelling Other _____

Rate the severity of the pain (1 = mild discomfort; 10 = severe pain): _____

Is the pain constant or does in come and go? _____

What treatment have you already received for your condition?

Medication Surgery Physical Therapy Other: _____

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

Health History:

Circle all that are applicable:

- | | | | |
|---------------------|------------------|----------------------|-------------------|
| Aids/HIV | Diabetes | Migraine Headaches | Stroke |
| Alcoholism | Emphysema | Miscarriage | Suicide Attempt |
| Allergy Shots | Epilepsy | Mononucleosis | Thyroid Problems |
| Anemia | Fractures | Multiple Sclerosis | Tonsillitis |
| Anorexia | Glaucoma | Mumps | Tuberculosis |
| Appendicitis | Goiter | Osteoporosis | Tumors, Growths |
| Arthritis | Gonorrhea | Pacemaker | Typhoid Fever |
| Asthma | Gout | Parkinson's Disease | Ulcers |
| Bleeding Disorders | Heart Disease | Pinched Nerve | Vaginal Infection |
| Breast Lump | Hepatitis | Pneumonia | Venereal Disease |
| Bronchitis | Hernia | Polio | Whooping Cough |
| Bulimia | Herniated Disc | Prostate Problems | Other: _____ |
| Cancer | Herpes | Prosthesis | _____ |
| Cataracts | High Cholesterol | Psychiatric Care | _____ |
| Chemical Dependency | Kidney Disease | Rheumatoid Arthritis | _____ |
| Chicken Pox | Liver Disease | Rheumatic Fever | _____ |
| Depression | Measles | Scarlet Fever | _____ |

Dates of exams: _____

(Women) Are you pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

List any types of surgeries you have had and the dates they occurred: _____

Please list all medications you are currently taking _____

Allergies _____

I certify that the above information is true to the best of my knowledge.

Patient Signature: _____ Date: _____