PATIENT INFORMATION

PATIENT NAME DOB

PREFERRED NAME PRONOUN

ADDRESS CITY ZIP

CELL/WORK PHONE E-MAIL

EMPLOYER OCCUPATION

PRIMARY PHYSICIAN TELEPHONE

EMERGENCY CONTACT TELEPHONE

WHO MAY I THANK FOR REFERRING YOU?

What condition would you like to have treated?

How long have you had this condition?

Have you been treated for this condition? If so, please explain

---

YOUR MEDICAL HISTORY

○ Alcoholism ○ Allergies ○ Arthritis ○ Asthma ○ Cancer ○ Depression ○ Diabetes
○ Epilepsy ○ Food Allergies ○ Headaches ○ Hypertension ○ Migraines ○ Skin Condition
○ Chronic Pain ○ Menstrual Issues ○ Digestive Disorders ○ Other
Date of last menstrual period

○ Surgery/Hospitalizations (list)
○ Medications/Supplements (list)

Tobacco use: None Past Present # of cigarettes day / week (circle)
Alcohol intake: None Past Present # of glasses/week wine / beer / liquor (circle)
Caffeine intake: None Past Present # of cups/day coffee / tea / soda (circle)

What is your current stress level? ○ None ○ Minimal ○ Moderate ○ Severe

Do you exercise regularly? ○ No ○ 1-2 times/week ○ 3-5 times/week ○ 5-7 times/week
What type of exercise? ○ Running ○ Bicycling ○ Swimming ○ Yoga/Pilates ○ Walking ○ Weights

How many hours to you sleep at night? ○ <5 ○ 6 ○ 7 ○ 8 ○ 9 ○ >10

FAMILY MEDICAL HISTORY ○ Adopted / Unknown
○ Alcoholism ○ Allergies ○ Arthritis ○ Alzheimer's ○ Cancer ○ Depression ○ Diabetes
○ Headaches ○ Heart Disease ○ Migraines ○ Osteoporosis ○ Stroke
○ Other

PLEASE READ AND SIGN NEXT PAGE:

CANCELLING OR CHANGING YOUR APPOINTMENT

Your appointment time is being held specifically for you. If you need to cancel or change your appointment, please call at least 24 hours in advance so that another patient may be accommodated at that time.

A late cancellation (less than 24 hours before an appointment) is subject to a $60 fee. A cancellation less than 4 hours before your appointment or a no-show without cancellation notice will be charged the full appointment fee (not your insurance copay).

If an emergency or illness prevents you from keeping your appointment, special arrangements can be made. If you are able to reschedule your appointment for the same week, the fee will be waived.

At the discretion of Holly N. Boland, patients arriving late might not be treated if it will cause Holly to run late for other patients, and the late patient will be required to pay for the appointment.

Thank you for your cooperation.

Please sign that you have read the above cancellation notice:

_____ _____

Signature *Date*