THE HOLISTIC CENTER AT BRISTOL SQUARE
hands on healing

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Neurological Integration Systems

Date _____

Name _____

Address _____

City, State, Zip _____

Home Phone _____ Mobile Phone _____

Email _____

Date of Birth _____ Age _____ ☐ M ☐ F

Referred By _____

Employer _____ Type of Work _____

Emergency Contact

Name _____

Relationship _____ Phone _____

Current Health

Overall Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Purpose of this Appointment _____

_____

_____

Other Health Concerns _____

_____

_____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If yes, please list doctor's name and if you are still seeing them:

_____

_____

Type of Treatment _____

Results _____

Current Medications / Drugs / Supplements

_____

_____

_____

Testing To Date ☐ X-rays / Ultrasound ☐ Cat Scans / MRIs / EEG

Laundry Detergent Brand _____

Do you use dryer sheets? ☐ Yes ☐ No If yes, what brand? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Do you drink coffee? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Burns, Tattoos or Piercings? ☐ Yes ☐ No If yes, where are they located? _____

Household Pets _____
(Or other other animals you or family members are in close contact with.)

Major Illnesses _____
(Approximate dates)

Surgeries _____
(Approximate dates)

Family History ☐ Cancer ☐ Diabetes ☐ Heart ☐ Other _____

I understand that this is an agreement between myself and the Doctor. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms as needed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate, as to the findings of my exam.

Patient Signature _____ Date _____