



Chisie G. Klingsmith, AP, DOM

402 North Babcock Suite 101 Melbourne FL, 32935 (Inside Health For Life Wellness Center)

Name: _____

Street Address: _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cellphone: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Marital Status: _____ Occupation: _____

Email: _____ Referred By: _____

Emergency Contact Person: _____ Contact #: _____

Primary Physician Name: _____ Contact # _____

General Information

What are you seeking treatment for today?

To what extent does your condition affect your daily activities (work, sleep, etc?)

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the issue by your Family physician? If Yes, what is the diagnosis?

Past Medical History

Family medical history

Are you currently taking any prescription medications? (Please include regularly used over the counter medications and supplements)

Medication Name	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments