



Personal Information

First Visit Date Día de la primera Visita
6 / 8 / 2017

| | | | | | |
|---|--------------------|-----------------------------------|--|---------------------------------|-------------|
| Name Nombre | ABA | DOB Fecha de Nacimiento | 11/11/1991 | Age Edad | 25 |
| | | | | Sex Sexo | Male |
| Address Direccion | 12345 ABC Street | City Ciudad | blank | Zip Codigo Postal | 1234234 |
| Email | aAccount@gmail.com | Phone Telefono | (Cell) (098)-765-4321 (Home) (123)-456-7890 | | |
| Emergency Contact Contacto de Emergencia | Big Bird | Phone Telefono | (305)-689-2530 | Relationship Relacion | Best Friend |
| Referred by Referido Por | Mr. Noodle | | | | |
| Do you have Allergies? Es alergica a algunas tipos de Medicamentos ? <input type="checkbox"/> Yes. Please Describe: Crayons <input checked="" type="checkbox"/> No. Si. Porfavor Describe: | | | | | |
| Check the box if you have ... <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p>High / Low Blood</p> <p><input type="checkbox"/> Pressure Presion Alta / Baja _____ / _____ mmHg</p> <p><input checked="" type="checkbox"/> Diabetes Diabeticos FPG: _____ mmolL</p> <p><input type="checkbox"/> High Cholesterol Colesterol Alto</p> <p><input type="checkbox"/> Epilepsy Epilepsia</p> <p><input type="checkbox"/> Cancer Cancer</p> </div> <div style="width: 48%;"> <p><input type="checkbox"/> Heart Condition Problema de Corazon</p> <p><input type="checkbox"/> Anemia Anemia</p> <p><input type="checkbox"/> Pacemaker Marcapasos</p> <p><input checked="" type="checkbox"/> Pregnant / Breast Feeding Embaradas / Tiene sintomas de Embarazo</p> <p><input type="checkbox"/> Sex Transmitted Disease Enfermedades Sexuales</p> </div> </div> | | | | | |
| What is your main concern today? Como te sientes en el día de Hoy ? | | | | | |
| <input type="checkbox"/> Pain: | | | <input type="checkbox"/> Depression | | |
| Description: Elmo's feet hurt. | | | <input type="checkbox"/> Sleep | | |
| <input type="checkbox"/> Headache: | | | <input type="checkbox"/> Menstruation | | |
| Location of Headaches: Elmos head hurts. | | | <input type="checkbox"/> Fertility | | |
| <input type="checkbox"/> Common Colds | | | <input type="checkbox"/> Weight Control | | |
| <input type="checkbox"/> High Blood Pressure | | | <input type="checkbox"/> Other: | | |
| <input type="checkbox"/> Stress | | | | | |
| Signature of Patient / Date Firma del Paciente / Fecha | | | Practitioner Signature Firma del Doctor | | |
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