SONRIDGE HEALTH & HEALING CENTER
3750 US1 South
St Augustine, FL 32086
Martin Monahan DC, NMD

Initial Patient Info Date:_____

Last Name, First Name, Middle Initial	
Gender (M or F)	
Birthdate (month/day/year ex. 05/25/1975)	
Email	
Phone Number (No Hyphens)	
Birthplace (ex. Orem, Utah, USA)	
Height (ex. 5 feet 6 inches)	
Weight (ex. 198lbs)	
Hair Color (as of age 8)	
Eye Color	
Current Address (include Street, City, State, & Zip)	

Please list, in order of importance, your top 5 health concerns. These may include physical, mental, and emotional ailments.

1. _____
2. _____
3. _____
4. _____
5. _____

I. What symptoms are you having?

II. Please list and date any disease name diagnoses you have received. (For example: "Lupus in 2012" , "Autoimmune Disease in 2015", "Lyme in 2013")

III. Have you ever been diagnosed with cancer? If so, when, and where was it located?

IV. What type of work do you do? Include occupation, hobbies, etc.

V. Do you smoke? If yes, what, how much, and for how long?

VI. Have you had any recent vaccinations? If yes, when?

VII. Please list and date all surgeries you have received.
Were there any complications?

VIII. Do you have a pacemaker or any other electronic implants? If yes, when did you receive it?

IX. Have you ever had a root canal or tooth extraction, if so approximately when it was performed?

X. How well do you sleep? (Number of hours)

MEDICATION SUMMARY

I. Please list ALL medications you are CURRENTLY taking. Include oral and topical preparations.

II. In the past 2 years, have you taken any antibiotics or steroids? If yes, please list.

III. Have you had any medical or dental surgical procedures in the past 2 years? If yes, was general, local, or spinal anesthesia used?

IV. Have you used any recreational drugs within the last 2 years?
If yes, please list.