GATEWAY NATURAL MEDICINE
& Diagnostic Center

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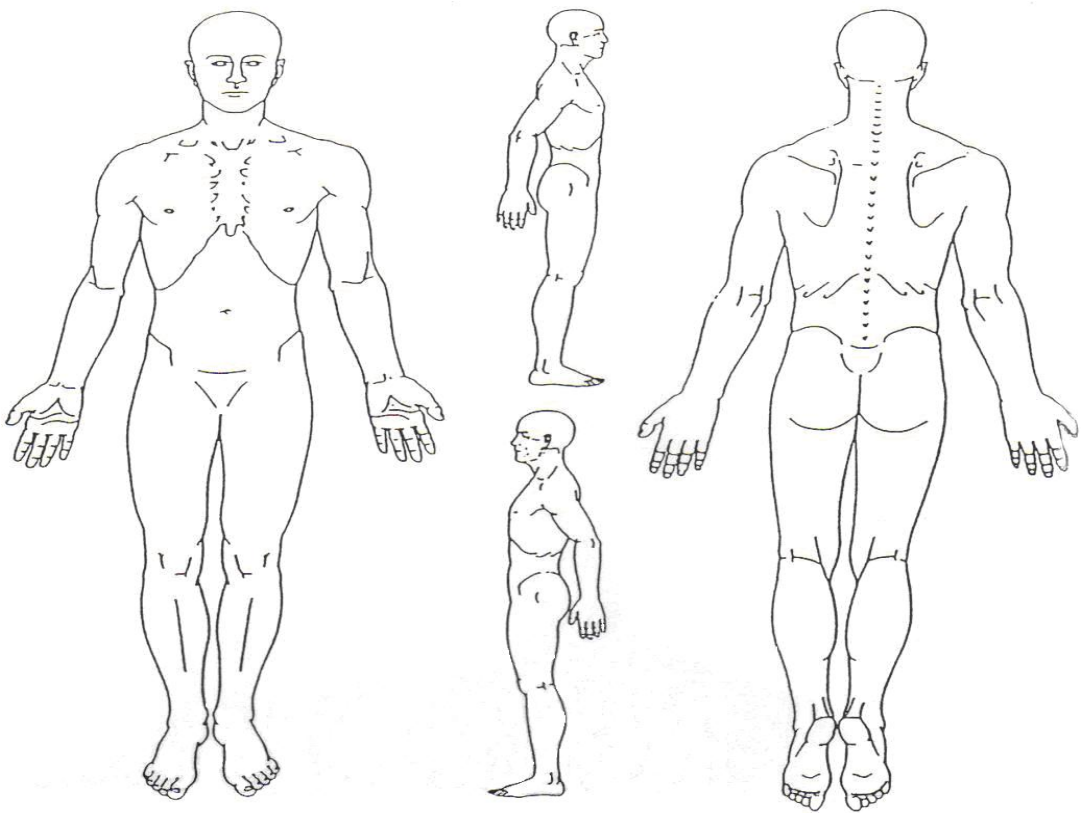
Patient's Name: _____ **Date:** _____
Address: _____ **City:** _____
State/Province: _____ **Zip/Postal Code:** _____
Date of Birth: _____ **Age:** _____ **Gender:** _____ ❒ **R** ❒ **L Handed**
Phone #: _____ **Email:** _____

Please mark the area and type of pain on the drawing using the following code:

N – Numbness
P – Pain
T – Tingling
A – Ache
S – Soreness
ST – Stiffness

Please mark all scars using the following: ++++



Right **Left** **Left** **Left** **Right**

What are your current complaints? _____

_____

_____

_____

Have you ever been diagnosed with cancer? ❒ Y ❒ N

Date: _____ Type: _____

Do you have any current diagnoses / diseases / conditions? ❒ Y ❒ N

List diagnoses / diseases / conditions: _____

Have you had any surgeries? ❒ Y ❒ N

List surgeries and dates: _____

Have you had any broken bones / fractures? ❒ Y ❒ N

List bones broken / fractures and dates: _____

Have you had any dental work in the past 2 months? ❒ Y ❒ N

Type of work and dates (give location – ex. rear upper molars): _____

Have you had a flu, cold, or respiratory illness in the past month? ❒ Y ❒ N

Do you suffer from any condition other than that which has been listed previously? ❒ Y ❒ N

If yes, what is it? _____

I have completed this 2-page form to the best of my ability.

Signature: _____ Date: _____

Office Use Only: Tech: _____ Re-Exam: ❒ Y ❒ N

Pt T: _____ F Rm T: _____ C

Image Series: ❒ Upper Body ❒ Lower Body ❒ Full Body ❒ Maxillofacial ❒ ROI