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Name: _____	Date: _____
Address: _____	
City: _____	State: _____ Zip: _____
Home Phone: _____	Work Phone: _____
Mobile Phone: _____	E-Mail: _____
Date of Birth: _____	Age: _____ Marital Status: _____
Referred by: _____	Occupation: _____
Physician: _____	Phone: _____
Address: _____	City: _____ State: _____ Zip: _____
In Emergency Notify: _____	Phone: _____

Main Complaint (**symptoms, diagnosis, duration, etc.**)

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Significant Trauma (physical or emotional)

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Birth History (prolonged labor, forceps delivery, complications, etc.)

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Surgeries (please include date of procedure)

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Allergies (chemical, environmental, food, drugs, etc.)

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Medications (names & dosages) please attach an additional page if necessary.

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Vitamins/Supplements/Herbs

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Exercise

Days per week

Length of workout

Type of Activity

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Diet

Meals per day

Snacks

Caffeinated Drinks

Alcohol per week

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What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

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What makes your condition worse? (Stress, fatigue, hunger, heat, certain foods, damp days etc.)

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**Personal History** Please check any conditions or symptoms you have now.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease              |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS         |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease          |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies      |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence                  |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema                  |
| <input type="checkbox"/> HIV/AIDS                |   |   |   |
| <input type="checkbox"/> Other _____             |   |   |   |

**Family Medical History** Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____            | <input type="checkbox"/> Seizures ____  | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____        | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____              |   |   |                                      |
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Please **check** if you have had any of these items listed below in the last **year**  
Put a **star** on the box if you had this in the past but do not any longer.

### General

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily                      | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Cravings                | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance                       | <input type="checkbox"/> Change in appetite  |
| <input type="checkbox"/> Bleed/Bruise easily     | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Peculiar tastes/smells             | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) |  |
| <input type="checkbox"/> Other _____             |   |   |  |

### Skin and Hair

- |   |                                      |  |   |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis   | <input type="checkbox"/> Itching              |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of hair                | <input type="checkbox"/> Recent moles         |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing        |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infection            | <input type="checkbox"/> Weak or ridged nails |
| <input type="checkbox"/> Other _____        |                                      |  |   |

### Head, Eyes, Ears, Nose and Throat

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Difficulty swallowing        | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Glasses         |
| <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness      | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Poor hearing                 | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems  |
| <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth         | <input type="checkbox"/> Facial pain     |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems              | <input type="checkbox"/> Jaw clicks/locks       | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Other _____          |   |   |  |

### Cardiovascular

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Varicose/spider veins  | <input type="checkbox"/> Pressure in chest    | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Dizziness            |  |
| <input type="checkbox"/> Other _____            |   |   |  |

### Respiratory

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing                       | <input type="checkbox"/> Coughing blood            | <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Bronchitis              |
| <input type="checkbox"/> Pneumonia                            | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest                  | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down |  | <input type="checkbox"/> Production of phlegm... what color? _____ |  |
| <input type="checkbox"/> Other _____                          |  |  |  |

### Gastrointestinal

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching             | <input type="checkbox"/> Black stools              | <input type="checkbox"/> Blood in stool        |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal pain               | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD     | <input type="checkbox"/> Hernia                    | <input type="checkbox"/> Poor appetite         |
| <input type="checkbox"/> Excessive appetite  | <input type="checkbox"/> Significant thirst   | <input type="checkbox"/> IBS/Crohn's Disease       |  |
| <input type="checkbox"/> Other _____         |   |  |  |

## Genito-Urinary

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination                                    | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> Urgent urination          |
| <input type="checkbox"/> Unable to hold urine                                 | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Scanty flow             | <input type="checkbox"/> Copious flow              |
| <input type="checkbox"/> Impotence  | <input type="checkbox"/> Sores on genitals  | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination         |
| <input type="checkbox"/> Premature ejaculation                                | <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Prostatitis             | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission                                   | <input type="checkbox"/> Pain in testicles  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Infections                |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ |   |  | <input type="checkbox"/> Excessive libido          |
| <input type="checkbox"/> Other _____  |   |  |  |

## Gynecological/Reproductive

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts                | <input type="checkbox"/> Age of first menses _____           |
| <input type="checkbox"/> Vaginal dryness               | <input type="checkbox"/> Endometriosis                | <input type="checkbox"/> Date of last menses _____           |
| <input type="checkbox"/> Vaginal sores                 | <input type="checkbox"/> Uterine Fibroids             | <input type="checkbox"/> Date of last PAP/Pelvic _____       |
| <input type="checkbox"/> Vaginal discharge             | <input type="checkbox"/> Fibrocystic breast tissue    | <input type="checkbox"/> Number of pregnancies _____         |
| <input type="checkbox"/> Infertility                   | <input type="checkbox"/> Polycystic Ovarian Disease   | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation        | <input type="checkbox"/> PMS                          | <input type="checkbox"/> Number of live births _____         |
| <input type="checkbox"/> Painful menstruation          | <input type="checkbox"/> Number of miscarriages _____ | <input type="checkbox"/> Number of abortions _____           |
| <input type="checkbox"/> Other _____                   |   |  |

Do you use birth control? \_\_\_\_\_

If yes, what type? \_\_\_\_\_ How long? \_\_\_\_\_

## Musculoskeletal

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Neck pain  | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel   |
| <input type="checkbox"/> Knee pain  | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain   | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis      |
| <input type="checkbox"/> Back pain Low___ Middle___ Upper___                            | <input type="checkbox"/> Bursitis        |  | <input type="checkbox"/> Rotator Cuff    |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) |  |  |  |
| <input type="checkbox"/> Other _____  |  |  |  |

## Neuropsychological

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Vertigo/Dizziness            | <input type="checkbox"/> Areas of numbness           |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Poor memory          | <input type="checkbox"/> Concussion                   | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Manic Depression             |  |
| <input type="checkbox"/> Other _____           |   |   |  |

Have you ever been treated for emotional problems?

Yes  No

Have you ever considered or attempted suicide?

Yes  No

Have you ever been treated for substance abuse?

Yes  No

**Comments** Please inform me of any other problems you would like to discuss.

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