

Significant Trauma (physical or emotional)

Surgeries (please include date of procedure)

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

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

Vitamins/Supplements/Herbs

Exercise

Days per week	Length of workout	Type of Activity	Do you smoke?
---------------	-------------------	------------------	---------------

Diet

Meals per day	Snacks	Caffeinated Drinks	Alcohol per week
---------------	--------	--------------------	------------------

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

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

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 |

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 _____ | | | |

Please **check below** 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) | |

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 |

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 |

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"/> Pacemaker |

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 | <input type="checkbox"/> Production of phlegm... what color? _____ | | |

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 Excessive |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

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 |

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 _____ |

Do you practice birth control? _____ 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 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) | |

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"/> |

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.
