General Information

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Address: _____ City: _____

State: _____ Zip code: _____ Phone (cell): _____ Work: _____

Genetic background: __ African American __ Hispanic __ Mediterranean __ Asian __

__ Native American __ Caucasian __ Northern European __ other: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

When, where and whom did you receive medical or health care last?

_____

How did you hear about our practice?

__ Social media __ Referral from doctor __ Referral from Friend/Family __ Website __Other**: _____**

Current Health Concerns

Rank in order current and ongoing health concerns

Describe the problem	Severity			Prior treatment/approach	Success		
	Mild	Moderate	Severe		(Excellent, Good, Fair)		
Ex: Post Nasal Drip	◉	○	○	*Elimination Diet*	◉	○	○
1.	○	○	○		○	○	○
2.	○	○	○		○	○	○
3.	○	○	○		○	○	○
4.	○	○	○		○	○	○
5.	○	○	○		○	○	○
6.	○	○	○		○	○	○

HEALTH HISTORY

CHECK **FAMILY MEMBERS** WHO HAVE HAD ANY OF THE FOLLOWING:

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Child 4	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age													
Age if deceased													
Cancer													
Heart Disease													
Hypertension													
Obesity													
Diabetes Type													
Stroke													
Autoimmune Disease													
Arthritis													
Kidney Disease													
Thyroid Problems													
Seizures/Epilepsy													
Psychiatric Disorders													
Anxiety													
Depression													
Asthma													
Allergies													
Eczema													
ADHD													
Autism													
Irritable Bowel Syndrome													
Dementia													
Substance Abuse													
Genetic Disorders													
Other:													

REVIEW OF SYSTEMS AND HEALTH HISTORY

Health History:

Please write **NO** or **NONE** for clarifications purposes

Surgery? _____ Illness? _____

Medications/Supplements? _____ Accidents? _____

WORK HISTORY: *Check all that apply*

__ Full Time __ Disabled __ Student __Unemployed __ Working less due to pain

__ Part Time __ Homemaker __ Retired __ Can't work due to pain

YOUR WORK MOSTLY INVOLVES: *Check all that apply*

__ Sitting __ Walking __ Light Labor __ Telephone __ Stress
__ Standing __ Heavy Labor __ Computer __ Repetition

SOCIAL HABITS:

Smoke? __ Yes __ No Drink? __ Yes __No

EXERCISE: *Check all that apply*

__ Almost None __ Weekly __ Cannot exercise due to pain
__ Daily __ 2-3x Weekly __ exercise less due to pain

NUTRITION: *Check all that apply*

__ Take daily supplements __ Vegetarian __ Out of control
__ diabetic __ Controlled __ Balanced

PERSONAL MEDICAL HISTORY: *Check if you have had any of the following*

Gastrointestinal
__ irritable Bowel Syndrome
__ GERD (reflux)
__ Crohn's Disease / Ulcerative Colitis
__ Peptic Ulcer Disease
__ Celiac Disease
__ Gallstones
__ SIBO
__ Other:

Cardiovascular
__ Agina
__ Heart Attack
__ Heart Failure
__ Hypertension (High Blood Pressure)
__ Stroke
__ High Blood Fats (Cholesterol, Triglycerides)
__ Rheumatic Fever
__ Arrhythmia (Irregular Heart Rate
__ Murmur
__ Mitral Valve Prolapse
__ Other:

Endocrine/ Metabolic
__ Diabetes Type:
__ Hypothyroidism (Low Thyroid)
__ Hyperthyroidism (Overactive Thyroid)
__ Polycystic Ovarian Syndrome
__ Infertility
__ Metabolic Syndrome / Insulin Resistance
__ Eating Disorder
__ Hypoglycemia
__ Other:

Urinary / Genital
__ Kidney Stone
__ Gout
__ Interstitial Cystitis
__ Frequent Yeast Infections
__ Sexual Dysfunction
__ Sexual Transmitted Diseases
__ Other:

Musculoskeletal
__ Fibromyalgia
__ Osteoarthritis
__ Chronic Pain
__ Other:

Neurological / Emotional
__ Epilepsy / Seizures
__ ADD / ADHD
__ Headaches
__ Migraines
__ Depression
__ Anxiety
__ Autism
__ Multiple Sclerosis
__ Parkinson's Disease
__ Dementia
__ Other:

Respiratory
__ Bronchitis
__ Asthma
__ Emphysema
__ Pneumonia
__ Sinusitis
__ Sleep Apnea
__ Other:

Skin
__ Eczema
__ Psoriasis
__ Acne
__ Skin Cancer
__ Other:

Inflammatory / Immune
__ Rheumatoid Arthritis
__ Chronic Fatigue Syndrome
__ Food Allergies
__ Environmental Allergies
__ Multiple Chemical Sensitivities
__ Autoimmune Disease
__ Mononucleosis
__ Hepatitis
__ Other:

Cancer
__ Lung
__ Breast
__ Colon
__ Ovarian
__ Skin
__ Other:

HEALTH HISTORY: *CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING*

Diagnostic Studies	Date	Additional Information
Bone Density		
CT Scan		
Colonoscopy		
Cardiac Stress Test		
EKG		
MRI		
Upper Endoscopy		
Chest Xray		
Other		

Injuries	Date	Additional Information
Concussion		
Head Injury		
Other		

Surgeries (Please List)	Date	Additional Information

Hospitalization	Date	Additional Information

SYMPTOM REVIEW: *Check if you have had any of the following*

GENERAL

__ Cold Hands & Feet
__ Cold Intolerance
__ Daytime Sleepiness
__ Fever
__ Fatigue
__ Difficulty Falling Asleep
__ Flushing
__ Early Waking
__ Can't Remember Dreams
__ Nightmares
__ Low Body Temperature

HEAD, EYES & EARS

__ Conjunctivitis
__ Ear Ringing/Buzzing
__ Headache
__ Loud Noise Sensitivity
__ Distorted Sense of Smell
__ Eye Crusting
__ Hearing Loss
__ Vision Problems
__ Distorted Taste
__ Eye Pain
__ Hearing Problems
__ Ear Fullness
__ Eye Margin Redness
__ Migraine

SYMPTOM REVIEW: *Check if you have had any of the following (CONTINUED)*

MUSCULOSKELETAL

__ Back Muscle Spasms __ Calf Cramps __ Chest Tightness __ Foot Cramps
__ Joint Deformity __ Joint Pain __ Joint Redness __ Joint Stiffness
__ Muscle Twitches: __ Muscle Weakness __ Neck Muscle Spasms __ Tendinitis
__ Around Eyes __Tension Headache __ TMJ Problems
__ Arms or Legs

MOOD / NERVES

__ Agoraphobia __ Anxiety __ Auditory Hallucinations __ Blackouts __ Depressions
__ Dizziness __ Fainting __Fearfulness __ Irritability __ Seizures
__Lightheadedness __Other Phobias __ Panic Attacks __ Paranoia __ Suicidal Thoughts
__ Tingling __ Tremor / Trembling __ Visual Hallucinations
__ Difficulty:
__ Concentrating __ With Balance __ With Thinking __ With Judgment __With Speech __ With memory

CARDIOVASCULAR

__ Angina / Chest Pain __ Breathlessness __ Heart Attack __ Heart Murmur
__ High Blood Pressure __ Irregular Pulse __ Vitral Valve Prolapse __ Palpitations
__ Swollen Ankles / Feet __ Varicose Veins __Phlebitis

URINARY

__ Bed Wetting __ Hesitancy __ Infection __ Kidney Disease
__ Kidney Stone __Urgency __Pain / Burning __ Leaking / Incontinence

DIGESTION

__ Anal spasms __ Bad Teeth __ Bleeding Gums __Blood in Stool
__ Burping __Canker Sores __ Cold Sores __ constipation
__ Cracking Corner Lips __ Poor Chewing with Dentures __ Diarrhea __ Periodontal Disease
__ Difficulty Swallowing __ Dry Mouth __ Flatulence __ Fissures
__ Foods “Repeat” (Reflux) __ Heartburn __ Hemorrhoids __ Liver Yeast / Jaundice
__ Lower Abdominal Pain __ Mucus in Stool __ Nausea
__ Sore Tongue __ Strong Stool Odor __ Undigested Food in Stool
__ Upper Abdominal Pain __ vomiting __ Bloating of Lower Abdomen
__ Bloating of Whole Abdomen __ Bloating After Meals __ Intolerance to lactose
__ Intolerance to All Dairy Products __ Intolerance to Gluten (Wheat) __ Intolerance to Corn
__ Intolerance to Eggs __ Intolerance to Fatty Foods __ Intolerance to Yeast

EATING

__ Binge Eating __ Can’t Gain Weight __ Can’t Lose Weight __ Carbohydrate Intolerance
__ Carbohydrate Craving __ Poor Appetite __ Salt Cravings __ Frequent Dieting
__ Sweet Cravings __ Caffeine Dependency __ Bulimia

RESPIRATORY

__ Bad Breath __ Bad Odor in Nose __ Dry Cough __ Productive Cough __ Hoarseness
__ Nasal Stuffiness __ Nose Bleeds __ Post Nasal Drip __ Sinus Infection __ Sinus Fullness
__ Snoring __ Sore Throat __ Wheezing __ Winter Stuffiness
__ Hay Fever:
__ spring __ Summer __ Fall __ Winter __ Change of Season

Continued…

NAILS

__ Bitten __ Brittle __ Curve Up __ Frayed __ Finger Fungus __ Toe Fungus
__ Pitting __ Ragged Cuticles __ Ridges __ Soft __ White Spots / Lines
__ Thickening of:
__ Fingernails __ Toenails

LYMPH NODES

__ Enlarged / Neck __ Tender / Neck __ Other Enlarged or Tender Lymph Nodes:
_____

SKIN DRYNESS

__ EYES __ Mouth / Throat __ Feet Cracking __ Feet Peeling __ Hair
__ & Unmanageable __ Hands Cracking __ Hands Peeling __ Scalp __ Dandruff
__ Skin in General

SKIN PROBLEMS

__ Athletes Foot __ Cellulite __ Dark Circles Under Eyes __ Ears Get Red __ Genital Herpes
__ Easy Bruising __ Jock Itch __ Moles with Color/Size Change __ Lackluster Skin __ Pale skin
__ Eczema __ Hives __ Patchy Dullness __ Oily Skin __ Psoriasis
__ Rash __ Red Face __ Sensitive to Poison Ivy/Oak __ Sensitive to Bites __ Shingles
__ Skin Cancer __ Skin Darken __ Strong Body Odor __ Thick Calluses __ Vitiligo

ITCHING SKIN

__ Anus __ Arms __ Ear Canals __Eyes __ Feet __ Hands
__ Legs __ Nipples __ Nose __ Genitals __ Roof of Mouth __ Scalp
__ Throat __ Skin In General

MALE REPRODUCTIVE *(skip if female)*

__ Discharge From Penis __ Ejaculation Problem __ Genital Pain __ Impotence
__ Infection __ Lumps in Testicles __ Poor Libido (Low Sex Drive)

FEMALE REPRODUCTIVE *(skip if male)*

__ Breast Cysts __ Breast Lumps __ Breast Tenderness __ Ovarian Cyst __ Endometriosis
__ Poor Libido (Sex Drive) __ Fibroids __ Infertility __ Vaginal Discharge __Vaginal Odor
__ Vaginal Itch __ Vaginal Pain
__ Premenstrual: __ Bloating __ Breast Tenderness __ Carbohydrate Craving __ Chocolate Craving
__ Constipation __ Diarrhea __ Fatigue __ Irritability __ Decreased Sleep
__ Menstrual: __ Cramps __ Heavy Periods __ Irregular Periods __ No Periods
__ Scanty Periods __ Spotting Between

READINESS ASSESSMENT & HEALTH GOALS

Rate on a scale of 1 (NOT WILLING) to 5 (VERY WILLING)

To improve your health, how willing are you to:	1	2	3	4	5
Significantly modify your diet	◯	◯	◯	◯	◯
Take several nutritional supplements each day	◯	◯	◯	◯	◯
Keep a record of everything you eat each day	◯	◯	◯	◯	◯
Modify your lifestyle (e.g., work demands, sleep habits)	◯	◯	◯	◯	◯
Practice a relaxation technique	◯	◯	◯	◯	◯
Engage in regular exercise	◯	◯	◯	◯	◯

Rate on a scale of 5 (VERY CONFIDENT) to 1 (NOT CONFIDENT AT ALL):	1	2	3	4	5
How confident are you to organize & follow through on above act.	◯	◯	◯	◯	◯

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

_____

_____

Rate on a scale of 1 (VERY UNSUPPORTIVE) to 5 (VERY SUPPORTIVE)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

Rate on a scale of 5 (VERY) frequent contact to 1 (VERY INFREQUENT CONTACT)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯

COMMENTS:

_____

Any additional information you would like to share:

_____

_____

_____

_____