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Please Do Not Wear Perfume or Cologne to the Clinic

Today's Date: _____ AGE: _____DATE OF BIRTH: _____.

NAME: _____.

If child, parents' names: _____

ADDRESS: Street_____ City _____ State _____ Zip_____

Phone: (H) _____ (W) _____ (CELL) _____.

Email: _____.

RELATIONSHIP STATUS:

___ Single and living alone

___ Single and living with partner

___ Married Spouse's name: _____

___ Children Names and ages: _____

OCCUPATION: _____

REFERRED BY: _____

What is your Chief or Primary Complaint(s) for today's office visit? _____

When did this Complaint start: _____?

What (if known) is the cause of the complaint?_____.

What factors aggravate your symptoms?_____.

What factors relieve your symptoms?_____.

Other Pertinent Information: _____

_____.

SECONDARY COMPLAINTS: _____

_____.

Please list all medications that you are currently taking. Include both prescription drugs as well as natural medicines (e.g., herbs, homeopathics, vitamin supplements, etc.): _____

_____

_____

_____.

Are you currently being treated by other health care providers? Yes___ No ___

√ Type: Name of Practitioner, and City:

____ Medical Doctor: _____.

____ Chiropractor: _____.

____ Naturopath: _____.

____ Oriental Medicine: _____.

____ Other: _____.

What is your blood type? _____.

How would you rate your current level of health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Please check (√) Yes or No to the following:

ENERGY LEVELS:

Are you fatigued, or do you fatigue easily? ___Yes___No.

Do you need to take naps? ___Yes___No.

Do you generally feel cold? ___Yes___No.

Do you have cold feet? ___Yes___No.

Do you have cold hands? ___Yes___No.

Do you ever have low grade fever? ___Yes___No.

Do your hands and cheeks warm up easily? ___Yes___No.

Do your feet get warm at nighttime, in bed? ___Yes___No.

Do you ever wake up sweating during the night? ___Yes___No.

(Men) - Do you have ejaculations during your sleep? ___Yes___No.

APPETITE AND TASTE:

Has your appetite altered recently? ___Yes___No. If yes, more hungry___or less hungry___.

Do you have a poor appetite? ___Yes___No.

Do you have poor digestion? ___Yes___No.

Do you have epigastric (stomach) distention or pain? ___Yes___No.

Do you have abdominal (large intestine) distention? ___Yes___No.

Are you experiencing belching? ___Yes___No.

Are you passing gas? ___Yes___No.

Do you have any of the following at least 3 times per week (Check √)

___Beef or Pork	___Candy	___Pretzels
___Eggs	___Chocolate	___Chips
___Milk	___Bread	___Fruit juice
___Soy milk	___Pasta	___Soda
___Yogurt	___Pizza	___Wine
___Ice cream	___Potatoes	___Beer
___Cookies	___Crackers	___Hard alcohol

List any suspected or known drug or food allergies: _____

_____

_____.

THIRST AND DRYNESS:

Do you have dry eyes? ____Yes____No.

Do you have dry nose or lips? ____Yes____No.

Do you have dry skin? ____Yes____No.

Do you have dry hair? ____Yes____No.

How many 8oz glasses of water do you drink daily? _____

How many 8oz glasses of other fluids do you drink daily? _____. What are they? _____

_____.

STOOLS AND URINE:

Are your stools: Please check (√)

___ Normal? (Daily with same shape and size)

___ Unusually Hard?

___ Unusually Loose?

___ Erratic in Form (sometimes hard, sometimes loose)?

___ Do you have bowel movements less than 5 times per week (constipation)?

___ Is there any blood, mucous or undigested food in your stool?

___ Do you have hemorrhoids?

Is your urine: Please check (√)

___ Unusually scanty and dark?

___ Unusually profuse and clear?

___ Do you wake more than once at night to urinate?

___ Do you experience any dribbling of urine?

___ Do you have an urgency to urinate?

___ Do you experience burning with urination?

SLEEP:

Do you suffer from insomnia? ____Yes____No.

If yes, do you fall asleep but wake up later? ____Yes____No.

Do you take medication for sleeping? ____Yes____No. If yes, how often? _____.

Do you have restless sleep? ____Yes____No.

Do you have uncomfortable dreams? ____Yes____No.

What time to you fall asleep? _____ What time do you get up? _____Total hours _____

EMOTIONS:

Do you experience excessive:

___Anger___Worry___Depression___Fear___Grief/Sadness ___ Anxiety___Moodiness___Irritability

Do you experience mood swings? ____Yes____No.

Are they related to eating OR not eating? ____Yes____No.

Do you take mood-regulating prescription medications?____Yes____No. If so, what drug and what dosage? _____.

STRUCTURE:

Do you suffer from chronic or occasional backache or neck ache? ____Yes____No.

Do you suffer from chronic or occasional joint pain? ____Yes____No.

Do any muscle aches or cramps? ____Yes____No.

ACCIDENTS:

Please list all major accidents, including fractures, deep cuts, serious sprains, etc. Please indicate all head injuries. Include dates or ages: _____

_____

_____

_____.

SURGERIES:

Describe reason, age, and any consequential outcome: _____

_____

_____

_____.

Have you ever had a blood transfusion? ___Yes ___No What year? _____.

EXERCISE:

What do you do for exercise? _____.

How often? _____.

DISEASE HISTORY:

Do your parents or siblings have any health problems?

If so, please explain. If they have passed away, state cause of death and age at death.

FATHER: _____

_____

_____.

MOTHER: _____

_____

_____.

SIBLINGS: _____

_____

_____.

During your mother's pregnancy with you, did she:

___ Drink alcohol

___ Smoke cigarettes

___ Take medications

___ Suffer serious illness

___ Suffer emotionally or physically

Please check √ if you have or have had any of the following:

Now	Past		Now	Past	
____	____	Anemia	____	____	Head injury
____	____	Arthritis	____	____	Headaches
____	____	Asthma	____	____	Heart murmur
____	____	Bruising	____	____	Heart palpitations
____	____	Cancer	____	____	Hepatitis: Type _____
____	____	Candida	____	____	Herpes
____	____	Cholesterol, high	____	____	Hypertension
____	____	Chronic fatigue	____	____	Hypotension
____	____	Constipation	____	____	Kidney stones
____	____	Depression	____	____	Low sex drive
____	____	Diabetes	____	____	Mental illness
____	____	Diarrhea	____	____	Mononucleosis

Now	Past		Now	Past	
____	____	Digestive problems	____	____	Nose bleeds
____	____	Dizziness, vertigo	____	____	Numbness, Neuropathy
____	____	Edema	____	____	Prostate problems
____	____	Epilepsy	____	____	Sciatic pain
____	____	Food allergies	____	____	Skin problems
____	____	Frequent colds	____	____	TMJ
____	____	Frequent gas	____	____	Ulcers
____	____	Gallstones	____	____	Venereal disease
____	____	Hayfever allergies	____	____	Parasites (type and date): _____.

Any other serious illness, injury or complaint? If so, name: _____

_____.

DRUG HISTORY: Please indicate current or previous use of the following: Please check (√)

Now	Past		Years usage
____	____	Anti-depressants, mood modifiers	_____
____	____	Antibiotics	_____
____	____	Antacids (Prilosec, Tagamet, etc.)	_____
____	____	Birth control pills	_____
____	____	Hormone replacement therapy	_____
____	____	Pain medication (Prescription)	_____
____	____	Steroids (Prednisone etc.)	_____
____	____	Tagamet or other antacids	_____
____	____	Thyroid medication	_____
____	____	Alcohol (in excess)	_____
____	____	Cigarettes	_____
____	____	Amphetamines (incl. methamphetamine)	_____
____	____	Cocaine	_____
____	____	Heroin	_____
____	____	Marijuana	_____

WOMEN ONLY:

Do you have a history of? Please check (√)

___ Amenorrhea (long time spans without a period)

___ Breast implants

___ Chronic vaginal or yeast infections

___ DES baby

___ Endometriosis

___ Hysterectomy. What year? _____

___ Irregular periods

___ Menstrual cramps

___ Miscarriage

___ Ovarian cyst

___ Pelvic Inflammatory Disease (PID)

___ Uterine fibroids

Birth control method (past or present); number of years usage: _____

_____.

Menstrual history.

Are you presently pregnant? ____Yes____No.

Are you presently suffering from menopausal disorder? ____Yes____No.

Have you completed menopause? ____Yes____No.

If yes, how many years past? _____.

If you are still having your periods:

Is your period regular? ____Yes____No.

How many days between your periods? _____.

How many days do your periods last? _____.

Are your periods painful? ____Yes____No.

Is your ovulation painful? ____Yes____No.

During menses, do you bleed excessively? ____ OR Too little? ____

Do you discharge clots? ____Yes____No.

What is the color of the blood during menses? _____.

Do you get headaches during menstruation or ovulation? ____Yes____No.

Do you suffer from premenstrual syndrome (PMS)? If yes, please indicate:

___ Breast distention

___ Irritability

___ Headache

___ Water retention

How many days before your period do the PMS symptoms begin? _____.

Pregnancy history:

How many times have you been pregnant? _____

Did you have difficulty getting pregnant? ___ Yes ___ No.

Did you have difficulty following childbirth? ___ Yes ___ No.

Have you had any abortions? ___ Yes ___ No. If so, how many? _____

Have you had any miscarriages? ___ Yes ___ No. If so, how many? _____