



Are you currently receiving health care? Y N

If yes, please list your current providers: \_\_\_\_\_

If no, when and where did you last receive medical care? \_\_\_\_\_

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

May we thank the person who referred you? \_\_\_\_\_

### SELF & FAMILY HISTORY

What hospitalizations or surgeries have you had? \_\_\_\_\_

Please list any recent labwork with any abnormal results? \_\_\_\_\_

What diagnostic imaging studies have you had?  Bone density scan  Mammogram  
 Electrocardiogram  Electroencephalogram  X-rays  CT scan  MRI  
 Ultrasound  Colonoscopy/Sigmoidoscopy  Other

### Medications and/or Supplements

Do you take or use any of the following?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Pain relievers (aspirin, ibuprofen) | <input type="checkbox"/> Sleeping Pills     | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Diet pills, appetite suppressants   | <input type="checkbox"/> Antibiotics        | <input type="checkbox"/> Laxatives     |
| <input type="checkbox"/> Cortisone (cream or pills)          | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Antacids      |

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking with dosages and brand names if possible:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

### General

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Weight one year ago: \_\_\_\_\_ lbs.

Maximum weight: \_\_\_\_\_ lbs. When? \_\_\_\_\_ Are you happy with your current wt? Y N

Energy Level:

- 1 2 3 4 5 6 7 8 9 10

When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

General State of Health: Poor Fair Good Excellent

As an adult

Teenager

Child

Is there any condition (physical, mental, emotional) from which you feel that you have not fully recovered?

---

**Family History**

Do you have a family history of any of the following (please circle)?

Alcoholism/addiction	Cataracts	Goiter	Mental Illness
Allergies	Celiacs	Hayfever/hives	Skin conditions
Anemia	Depression	Headaches/Migraines	Stroke
Arthritis	Diabetes	Heart Disease	Suicide
Asthma	Liver Disease	Heart Murmur	Thyroid Problems
Autoimmune	Epilepsy	High Blood Pressure	Tuberculosis
Cancer, type?	Gall Bladder Disease	Kidney Disease	Other _____

Is your father living? Yes; his age \_\_\_\_ No; age at time of death \_\_\_\_ Cause of death \_\_\_\_\_

Is your mother living? Yes; her age \_\_\_\_ No; age at time of death \_\_\_\_ Cause of death \_\_\_\_\_

Do you have siblings? If so, how is their health? \_\_\_\_\_

**Childhood Illnesses**

Please circle whether you have/had any of the following conditions as a child/adolescent:

Diphtheria	Mumps
German measles	Rheumatic fever
Measles	Scarlet fever
Other _____	

**Past Immunizations**

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria	Polio
Measles/Mumps/Rubella (MMR)	Tetanus
Pertussis	Other _____

**REVIEW OF SYSTEMS (self)**

Please circle. Y= Yes, present condition P=Problem in the past N=No, never had the condition  
Please ask if you don't know what something is.

**Head**

Headaches	Y P N	Migraine Headaches	Y P N
Head injury	Y P N	Jaw/TMJ Problems	Y P N

**Ears**

Ringings	Y P N	Excess Wax	Y P N
Earaches	Y P N	Impaired Hearing	Y P N

**Neck**

Lumps	Y P N	Swollen Glands	Y P N
Goiter	Y P N	Pain or Stiffness	Y P N

### Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, Hives	Y P N
Lumps	Y P N	Acne, Boils	Y P N	Color Changes	Y P N
Itching	Y P N	Loss of Hair	Y P N	Night Sweats	Y P N

### Musculoskeletal

Joint pain/stiffness	Y P N	Muscle Spasms	Y P N	Weakness	Y P N
Arthritis	Y P N	Broken Bones	Y P N	Sciatica	Y P N
Osteoporosis	Y P N	Muscle Pain	Y P N		

### Eyes

Blurred Vision	Y P N	Cataracts	Y P N	Glasses/Contacts	Y P N
Eye Pain/Strain	Y P N	Glaucoma	Y P N	Tearing/Dryness	Y P N
Spots in Eyes	Y P N	Color Blind	Y P N	Double Vision	Y P N
Recent Vision Changes	Y P N	Last Eye Exam	_____		

### Nose/Sinuses

Stuffiness	Y P N	Loss of Smell	Y P N	Sinus Problems	Y P N
Hayfever	Y P N	Nose Bleeds	Y P N	Frequent Colds	Y P N

### Mouth/Throat

Hoarseness	Y P N	Gum Problems	Y P N	Freq. Sore Throat	Y P N
Jaw Clicks	Y P N	Dental Cavities	Y P N	Sore Lips/Tongue	Y P N
Teeth Grinding	Y P N	Dry Mouth	Y P N	Change in Thirst	Y P N

### Respiratory

Asthma or wheezing	Y P N	Tuberculosis	Y P N	Spitting up Blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty Breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with Breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N		
Shortness of Breath:	Y P N	At Night	Y P N	Lying Down	Y P N

### Cardiovascular

Angina	Y P N	Chest Pain	Y P N	Blood Clots	Y P N
Murmur	Y P N	Heart Disease	Y P N	Rheumatic Fever	Y P N
Easy Bruising	Y P N	Ankle Swelling	Y P N	Valve Problems	Y P N
Elevated Cholesterol	Y P N	High/Low Blood Pressure	Y P N	Poor Circulation	Y P N
Deep Leg Pain	Y P N	Palpitations	Y P N	Varicose Veins	Y P N

### Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Changes in Appetite	Y P N
Ulcers	Y P N	Black Stool	Y P N	Coughing up Blood	Y P N
Jaundice	Y P N	Hemorrhoids	Y P N	Gall Bladder Disease	Y P N
Heartburn	Y P N	Abdominal Pain	Y P N	Blood in Stool	Y P N
Trouble Swallowing	Y P N	Belching	Y P N	Passing Gas	Y P N
Liver Disease	Y P N	How many bowel movements per day?	_____		

**Urinary**

Incontinence Y P N      Frequent Infections Y P N      Painful Urination Y P N  
Kidney stones Y P N      Frequency Y P N      Urgency Y P N

**Blood/Peripheral Vascular**

Anemia Y P N      Cold Hands/Feet Y P N      Thrombophlebitis Y P N  
Leg Pain Y P N      Easy Bruising Y P N      Varicose Veins Y P N

**Neurological**

Fainting Y P N      Paralysis Y P N      Numbness/Tingling Y P N  
Seizures Y P N      Loss of Memory Y P N      Muscle Weakness Y P N

**Mental/Emotional/Behavioral**

Mood Swings Y P N      Eating Disorder Y P N      Tension/Stressed Y P N  
Anxiety Y P N      Depression Y P N      Thoughts of Suicide Y P N  
Substance Abuse Y P N      Nervousness Y P N

**Endocrine**

Hypothyroid Y P N      Excessive Thirst Y P N      Cold Intolerance Y P N  
Hyperthyroid Y P N      Excessive Hunger Y P N      Heat Intolerance Y P N

**Reproductive**

Sexual Orientation \_\_\_\_\_ Are you sexually active? Y P N  
Type of birth control (if applicable) \_\_\_\_\_  
Discharge or Sores Y P N      Hernias Y P N      Sexual Difficulty Y P N  
Venereal Infection Y P N      Date of STD/STI testing? \_\_\_\_\_

**MALE Reproductive**

Testicular Masses Y P N      Prostate Issues Y P N      Testicular Pain Y P N  
Impotence Y P N      Premature Ejaculation Y P N  
Date of last physical exam? \_\_\_\_\_

**FEMALE Reproductive**

Age of first menses \_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_  
Length of cycle \_\_\_\_\_ Duration of menses \_\_\_\_\_  
Date of last annual exam? \_\_\_\_\_ Any previous abnormal paps? Y N  
Painful menses Y P N      Endometriosis Y P N      Ovarian cysts Y P N  
Heavy flow Y P N      Fertility issues Y P N      Cervical dysplasia Y P N  
Breasts tender Y P N      PMS Y P N      Bleeding between cycles Y P N  
Sexually active Y P N      Cycles regular Y P N      Menopausal symptoms Y P N  
Hormone Therapy Y P N      Breast lump(s) Y P N      Trouble Conceiving Y P N  
Nipple discharge Y P N      Do self breast exams Y P N      Fibrocystic breast Y P N  
# of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # of abortions \_\_\_\_\_

**Is there anything else you would like us know in order to serve you better?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any physical limitations? \_\_\_\_\_

What is/are the main goals for your visit to our clinic today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Habits

Please write what you last had for breakfast, lunch, dinner, snacks in the last 24 hours:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Fluids (guess amounts): \_\_\_\_\_

Do you have any dietary restrictions and why? \_\_\_\_\_

\_\_\_\_\_

Please indicate the following:

Smoke: Y N If yes, amount: \_\_\_\_\_ Alcohol: Y N If yes, amount: \_\_\_\_\_

Caffeine (soda, coffee, tea, etc...): Y N If yes, amount: \_\_\_\_\_

Watch TV: Y N

Exercise: Y N If yes, amount and type: \_\_\_\_\_

Main Interests/Hobbies: \_\_\_\_\_

Do you have a spiritual practice: Y N

How many hours do you sleep? \_\_\_\_\_ Do you wake rested? Y N

Do you have any stress management practices? Y N

What do you do to relax? \_\_\_\_\_

Do you have a good support system (friends, family)? \_\_\_\_\_

Exposed to chemicals/tobacco at home or at work? Y N If yes, list: \_\_\_\_\_

How motivated are you to make changes in your life to improve your health (10=most)?

1 2 3 4 5 6 7 8 9 10

What changes are you willing to make to improve your health?

Lifestyle Changes Take Supplements

Exercise Nutrition changes

Smoking Cessation Sleep Patterns

Counseling Alcohol reduction/cessation

Recreational Hours/Hobbies

*Thank you*

---

