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Personal Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Email _____

Date of Birth _____ Age _____ Gender: ___Male ___Female ___Transgender

Marital Status: S M D W Name of Spouse/Partner _____

Occupation _____ Number of Children (if any) _____

Name of Child	Age	Sex	Any Conditions or Physical Concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Health Condition

Overall Health (Circle One): Excellent Good Fair Poor Other: _____

Primary reason you are here: _____

_____

Today's condition started when? _____

What activities aggravate your condition? _____

What activities lessen your condition? _____

Is condition worse during certain times of day? _____

Is this condition interfering with: Work? _____ Sleep? _____ Routine? _____

How is your condition progressing (Circle One): Worse? _____ Better? _____ Same? _____

Other doctors seen for this condition _____

Type of Treatment _____ Results _____

Type of Treatment _____ Results _____

Type of Treatment _____ Results _____

Drug Allergies: _____

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Medical History

- ☐ Ringing in Ear
- ☐ Ear Infection - Frequent
- ☐ Dizziness / Fainting
- ☐ Failing Vision
- ☐ Eye Infections
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Sore Throats - Frequent
- ☐ Hay Fever / Allergies
- ☐ Pneumonia
- ☐ Bronchitis / Chronic Cough
- ☐ Asthma / Wheezing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Swollen Ankles
- ☐ Leg Pain - Walking
- ☐ Varicose Veins / Phlebitis
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Indigestion or Heartburn
- ☐ Persistent Nausea/Vomiting
- ☐ Peptic Ulcers
- ☐ Abdominal Pain - Chronic
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Crohn's / Colitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Urine Infections - Frequent
- ☐ Blood in Urine
- Urination:
  - ☐ Overnight > Than Twice
  - ☐ Painful
  - ☐ Loss of Control
  - ☐ Decrease in Force / Flow
- ☐ Kidney Stones
- ☐ Venereal Disease
- ☐ Urethral Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss - Recent
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremor / Hands Shaking
- ☐ Muscle Weakness
- ☐ Numbness / Tingling Sensations
- ☐ Headaches - Frequent
- ☐ Arthritis / Rheumatism
- ☐ Osteoporosis
- ☐ Back Pain - Recurrent
- ☐ Bone Fracture / Joint Injury
- ☐ Gout
- ☐ Foot Pain
- ☐ Cold Numb Feet
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis / Eczema
- ☐ Nervousness
- ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness - Excessive
- ☐ Phobias
- ☐ Mental Illness
- ☐ Lactose Intolerance
- ☐ Prostate Disease
- ☐ Sexual/Menstrual Dysfunction
- ☐ Frequent Infections
- ☐ Diphtheria
- ☐ Tetanus
- ☐ Chicken Pox
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Other _____
- ☐ Other _____

Females - Please Complete

Pregnant? _____ Yes _____ No
Planning Pregnancy? _____ Yes _____ No
Menstrual Flow:

- ☐ Regular
- ☐ Irregular
- ☐ Pain / Cramps

_____ Days of Flow
_____ Length of Cycle
Date - 1st day of last period:
_____

Number of:

_____ Pregnancies
_____ Abortions
_____ Miscarriages
_____ Live Births

Birth Control Method: _____

B.C. Pill (Name) _____

☐ Flushing / Menopause

Date of Last PAP Test _____

- ☐ Normal
- ☐ Abnormal

Date of Last Mammogram _____

- ☐ Normal
- ☐ Abnormal

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Medications / Supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Accidents and Hospitalizations

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Habits / Lifestyle

Alcohol
- Type _____
- Amount _____

Sleep
- Difficulty falling asleep Y / N
- Difficulty staying asleep Y / N
- Daytime drowsiness Y / N

Overall Stress
- Low / Moderate / High
- Yoga / Meditation / Other
- Vacation weeks per Year _____

Smoking
- Packs daily _____
- How long _____
- Interested in stopping? _____

Exercise
- Frequency _____
- Type of Exercise _____
- _____

Caffeine: Coffee, Tea
- Cups daily _____

Sugar
- Sodas: Daily _____
- Cookies / Candies / Ice Cream
- Artificial Sweetener Y / N

Toxic Exposure
- Eat Organic: Strictly / Mostly / Rarely / No
- Farmer Y / N

Silver or Mercury Filling Y / N
Filtered Water Y / N
Swim Often in Chlorinated Pool Y / N
Plastic Water Bottles Y / N
Mold Exposure Y / N
Heavy Chemicals Y / N
Painter Y / N
Dentist Y / N
Microbial Balance:
- Frequent Antibiotics Y / N
- Breast Fed > 1 Year Y / N

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Diet Diary

Please Describe your Typical Diet

Breakfast	Lunch	Dinner

Morning Snack	Afternoon Snack	Evening Snack

Water / Beverages	Water / Beverages	Water / Beverages

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Food Sensitivities

Please list the foods you are sensitive to, what happens when you eat it and how often you eat it.

	Sensitive?	If yes, what happens when you eat it?	Are you avoiding it?
Gluten	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Dairy	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Eggs	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Corn	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Sugar	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Nuts	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Beans	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Soy	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Other	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding
Other	Y / N	_____	____ Yes, Strictly ____ Limiting, but not Strictly ____ Not Avoiding

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Family History

Please give the following information about your immediate family:

Relationship	Age if Living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Brothers / Sisters			
Spouse			
Children			

Have any Blood Relatives had any of the following Illnesses? If so, please indicate relationship.

Illness	Family Member
Diabetes	
Cancer	
Blood Disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Tuberculosis	
Gout	
High Blood Pressure	
Heart Disease	
Back Problems	

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