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All information will be held in the strictest confidence. Feel free to add details not covered.

Name:

Mailing Address:

City, State, Zip:

Preferred Phone:

Secondary Phone:

Fax:

email address:

Birth date:

Height & Weight:

Emergency Contact:
(Name & Number)

Referred by:

MAJOR COMPLAINTS:

What diagnosis, if any, have you been given?

Diseases (check all that apply & any treatments)

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Reactions to childhood, tourist or military vaccinations | | |
| <input type="checkbox"/> Other (please specify) | | |

Surgeries (include year):

Significant Trauma: (Describe accidents, falls, etc., with dates, treatment, results)

Allergies:

Family Medical History: (Please explain and identify family member in relation to you)

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Medicines taken within the last two months (including vitamins, drugs, herbs, etc.)

How many cigarettes do you smoke a day?

How much coffee, tea or cola do you drink a day?

How much alcohol do you drink during a typical week?

PLEASE EXPLAIN if you have had any of the following within the last 3 months:

GENERAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Strong Thirst (cold/hot drinks) | <input type="checkbox"/> Poor Sleeping/Trouble Sleeping | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Sweating Easily | <input type="checkbox"/> Chills | <input type="checkbox"/> Food Cravings |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Energy Drop* |
| <input type="checkbox"/> Cravings (all that apply): | | *Time of day? |
| Sugar Salt Sour Spicy Fats | | |

SKIN AND HAIR:

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itches | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Change in Hair or Skin Texture | | |
- Any other hair or skin problems?

HEAD, EYES, EARS, NOSE AND THROAT:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussion/s | <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"/> Blurry Vision | <input type="checkbox"/> Ear Aches |
| <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 |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Clicking Jaw | |
| <input type="checkbox"/> Headaches - Where and When? | | |

Any other head or neck problems?

CARDIOVASCULAR:

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hand or Feet | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Swelling in Feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in Breathing |

Any other heart or circulatory problems?

RESPIRATORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with Deep Breaths |
| <input type="checkbox"/> Difficulty Breathing if Lying Down | | |
| <input type="checkbox"/> Production of Phlegm - What color? | | |

Any other lung problems?

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 Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | | <input type="checkbox"/> Chronic Laxative Use |

Any other problems with your stomach or intestines?

GENITO-URINARY:

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Impotency |

Waking Up at Night to Urinate - How frequently?

Any particular color to your urine?

Any other problems with your genital or urinary system?

REPRODUCTIVE AND GYNECOLOGIC:

Pregnancies:_____ Date of Last Menses:_____ () Irregular Periods
Births: _____ Duration of Menses:_____ () No Periods
Miscarriages:_____ Days between:_____ () Breast Lumps/Pain
Abortions:_____ Flow: () Heavy () Light () Chronic Yeast Infections
Date of Last PAP: _____
Clots: () Dark () Red () Menopause - Age:_____

Birth Control (What type? For How Long?):

Pain throughout Menstrual Cycle (Check all that apply):

() Beginning () Ending () Ovulation

Vaginal Discharges/Leukorrhea (please describe):

PMS Changes in Body & psyche (When? Symptoms?):

Other Conditions:

MUSCULOSKELETAL:

() Neck Pain () Muscle Pains () Knee Pain
() Back Pain () Muscle Weakness () Foot/Ankle Pains
() Hand/Wrist Pain () Shoulder Pain () Hip Pain

Any other joint or bone problems?

NEUROPSYCHOLOGICAL:

() Seizures () Dizziness () Loss of Balance
() Areas of Numbness () Lack of Coordination () Poor Memory
() Concussion () Depression () Anxiety
() Bad Temper () Low Tolerance for Stress

Have you ever been treated for emotional problems?