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Date: / /

Last name	First name	Middle initial
Date of Birth:	Weight: Height:	Gender: M F
Marital Status (circle one): Single Married Widowed Divorce		
Home Address: Street/City/State/Zip code:		
Cell Number:	Home Number:	
Email:	Who referred you:	
Occupation/Employer:		
Emergency contact & phone #:		
Primary care physician and phone #:		

CURRENT HEALTH PROBLEMS DESCRIPTION AND BRIEF HISTORY:

MEDICATIONS & SUPPLIMENTS LIST:

_____

_____

_____

_____

FAMILY HISTORY: check any which has effected your parents, grandparents, siblings, children.

Condition	Relative/s Affected	Condition	Relatives Affected	Condition	Relatives Affected
□ Addiction(s)		□ Depression		□ High Blood P.	
□ Allergies		□ Diabetes		□ Lung Problem	
□ Arthritis		□ Digestive		□ Overweight	
□ Asthma		□ Genetic Disease		□ Stroke	
□ Heart Disease		□ Bleeding		□ Thyroid	
□ Migraine		□ Cancer		□ Other	

YOUR HISTORY: Check any of the following that you have now or ever have had.

□ Alcoholism
□ Arthritis
□ Anxiety/Depression
□ Autoimmune Disease
□ Bladder/Kidney
□ Cancer
□ Stomach Problems
□ Intestinal Problems
□ Asthma
□ Sinus / Upper Respir
□ Genetic Condition
□ Stroke
□ High Blood Pressure
□ Heart Disease
□ Thyroid: Hypo or Hyper
□ Hormone problems
□ Muscle Problems
□ Neurological Prob
□ Headaches
□ Epilepsy/Seizures
□ Eczema/Skin Prob
□ TMJ / Jaw Dysfunction
□ Diabetes
□ HIV/AIDS
□ Herpes
□ Mono
□ Weight Loss
□ Weight Gain
□ Ear Infections/Prob
□ Eye Problem

ALLERGY / REACTOINS TO:

Foods?
□ Milk products
□ Wheat or other grains
□ Gluten
□ Nuts
□ Others:

Inhalants?
□ Dust
□ Grass. trees. pollen
□ Animal dander
□ Mold
□ Others:

Chemicals?
□ Medication
□ Cosmetics, detergents, perfumes
□ Gas, glues, newsprint. paint, dye
□ Chlorine, formaldehyde
□ Others:

HOSPITALIZATIONS & MAJOR INJURY: **DATE:**

Females Last menses? _____ Menopause? □ Yes □ No
# of pregnancies ___ # of children___

Males Prostatitis: □ Yes □ No
Frequent urination: □ Yes □ No Incontinence: □ Yes □ No

ACTIVITY LEVEL:
□ Sedentary
□ light: light daily work and no regular exercise
□ Moderate: light daily work and exercise 3 X week
□ Sustained: daily work and exercise 5 X week
□ Heavy: heavy work and heavy exercise 5 X week

STRESSORS AFFECTING YOUR LIFE:
□ Difficulties with work or lifestyle
□ Recent change in marital status
□ Death or serious illness family or friend
□ Lack of love or fulfilling relationships
□ Illness - self!

Review of Systems

Symptoms	Past	Now	Comments
General / Immune			
Frequent Fatigue			
Hot / Heat Intolerant			
Perspire Easily			
Frequent Infections			
Endocrine			
Cold Extremities			
Thyroid Disorder			
Low Blood Pressure			
Low body temperature			
Others:			
Skin			
Acne, Eczema, Dermatitis			
Hives / Rashes			
Itch Burning, Dry			
Ears			
Ringing /tinnitus			
Ear infection			
Itching			
Pain			
Head and Neck			
Headaches			
Migraines			
Head injury			
Face / Jaw Pain			
Neck Pain, Stiff Neck			
Eyes			
Blurred Vision			
Dry Eyes			
Burning / Itching			
Floaters (see Spots)			
Glaucoma / Retina Problems			
Light Sensitive			

Symptoms	Past	Now	Comments
Nasal			
Sinusitis			
Rhinitis			
Congestion			
Headache /forehead			
Mouth/Throat			
Bleeding Gums			
Grinding Teeth			
Swallowing problem			
Mouth ulcer			
Digestive			
Acid Reflex			
Bloating / Gas			
Belching			
Food Allergy			
Colitis / Irritable Bowel			
Constipation			
Diarrhea			
Ulcer/ Gastritis			
Nausea / Vomiting			
Liver Disease			
Gall Bladder			
Celiac Disease			
Respiratory			
Bronchitis			
Asthma			
Chemically Induced Problems			
Colds + Flu (frequent)			
Cough - chronic			
Shortness of Breath			

Symptoms	Past	Now	Comments
Cardiovascular			
High Blood Pressure			
Palpitations / Tachycardia			
Others:			
Muscles & Joints			
Arthritis/Joint Pain			
Back Pain / Disc Problems			
Bursitis/Tendonitis			
Muscle Aches / Pains			
Muscle Cramps / Spasms			
Muscle Weakness			
Neurological			
Clumsy			
Convulsions / Seizures			
Neuralgia I Tingling			
Numbness			
Raynaud's			
Spastic Motion / Tremors			
Urinary			
Bladder Infectious - frequent			
Blood in Urine			
Frequent Urination			
Incontinence			
Pain, Burning			
Behavioral & & Psychological			
Addictions (list)			
Anxiety			
Attention Deficit (ADD)			
Depression			
Eating Disorder (list)			
Fearful / Worrier			
Hyperactive / Manic			
Insomnia			
Phobias			
Memory Problems			
Mood Swing			
Obsessive / Compulsive			

Symptoms	Past	Now	Comments
Female			
Breast problems			
Ovarian /Uterine problems			
Fibroids / Cysts			
Period: irregular / Cramps			
Infertility			
Endometriosis			
Sexually Transmitted Dis.			
Hormone Replacement			
Peri-menopausal			
Menopausal: Natural / Surgical			
Hot Flash			
Night sweat			
Vaginal Dryness			
Osteoporosis			
Male			
Prostate Problem			
Weak Urination			
Sexually Transmitted Dis.			
Other:			
Foods / Glucose Tolerance			
Afternoon Drowsiness			
Cravings : Butter/Fats			
Fatigue After Eating			
Hunger Headaches			
Hunger Irritability			
Other			
Best time of the day			
Worst time of the day			
Best season for you			
Worst season for you			