Name ____ Today's date ____________

Age _____Date of Birth ______________ Date of last physical examination ____________

Physician name /phone number ____

What is the reason for your visit today? ____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

____

What was the outcome ____

What types of therapy have you tried for this problem(s)? Circle all that applies

diet modification   fasting   vitamins/minerals   herbs   homeopathy

chiropractic   acupuncture   conventional drugs

Symptoms Do you experience any of these general symptoms EVERY DAY? Check all that apply

	Debilitating fatigue		Shortness of breath		Insomnia		Constipation		Chronic pain/inflammation
	Depression		Panic attacks		Nausea		Fecal incontinence		Bleeding
	Disinterested in sex		Headaches		Vomiting		Urinary incontinence		Discharge
	Disinterest in eating		Dizziness		Diarrhea		Low grade fever		Itching/rash

Allergies

____
____
____
____
____

Current Medications

____
____
____
____
____

Circle the level of stress you are experiencing on a scale from 1-10 (1 being the lowest)

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (changes in job, work, residence or finances, legal problems ______________________________

____

Pharmacy/phone/city ____

Family History

Relationship	Age	State of Health	Cause of Death/ age
Father			
Mother			
Brothers			
Sisters			

Other Family History concerns:

____
____
____

Check if your blood relatives had any of the following health concerns

		Relationship to you			Relationship to you
	Arthritis			Heart disease	
	Asthma			Infertility	
	Chemical Dependency			Learning Disabilities	
	Alzheimer's			Mental Illness	
	Cancer			Mental Retardation	
	Depression			Migraine headaches	
	Diabetes			Neurological disorders	
	Drug Addiction			Obesity	
	Eating disorder			Osteoporosis	
	Genetic disorder			Stroke	
	Glaucoma			Suicide	

Personal Health History - check all that apply

	Arthritis		Depression		Heart disease		Osteoporosis
	Allergies/hay fever		Diabetes		Infection, chronic		Pneumonia
	Asthma		Diverticular disease		Inflammatory bowl disease		Sexually transmitted disease
	Alcoholism		Drug addictions		Irritable bowel syndrome		Seasonal affective disorder
	Alzheimer's		Eating disorder		Kidney/bladder disease		Skin problems
	Autoimmune disease		Epilepsy		Learning disabilities		Tuberculosis
	Blood pressure problems		Emphysema		Liver/gallbladder disease		Ulcer
	Bronchitis		Eyes, ears, nose, throat problems		Mental illness		Urinary tract infection
	Cancer		Environmental sensitivities		Mental retardation		Varicose veins
	Chronic Fatigue Syndrome		Fibromyalgia		Migraine headaches		Other-
	Carpal tunnel syndrome		Food intolerance		Neurological problems		Corrective lenses
	Cholesterol, elevated		Gastroesophageal reflux disease		Sinus problems		Hearing aids
	Circulatory problems		Genetic disorder		Stroke		Dentures
	Colitis		Glaucoma		Thyroid trouble		Medical devises/prosthetics
	Dental problems		Gout		Obesity		Implants ____________

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ______ If yes, when ___________________

Serious Illness/injuries	Date	Outcome

Occupation

____

Does your work environment expose you to:
Stress ________
Heavy Lifting ________
Hazardous substance ________
Health/life threatening activities

____

Other ____________________________

Do you consider yourself:

◊ Underweight

◊ Overweight

◊ Just right

Your weight today __________

Have you had an unintentional weight loss or gain of 10 pound or more in the last three months? __________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I , or my minor child, ever have a change in health.

Signature of Patient/Parent/Guardian ____Date ____________________

Print Name of Patient/Parent/Guardian ____Relationship to Patient _________________

Reviewed by ______________________________ Date ______________

Medical- Women

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased six drive
- ☐ Sexually transmitted disease

Other ____________________

Age of first period ____________

Date of last gynecological exam________

Mammogram

- ☐ +
- ☐ -

PAP

- ☐ +
- ☐ _

Form of Birth Control _____________

Number of children _______________

Number of pregnancies ____________

- ☐ C-Sections _________
- ☐ Surgical menopause
- ☐ Menopause

Date of last menstrual cycle _________

Length of cycle _______ days

Time between cycles _______ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty ____________________

Medical – Men

- ☐ Benign prostatic hyperplasia (BHA)
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease
- ☐ Other ____________________

Health Habits

- ☐ Tobacco

Cigarettes: #/day _____

Cigars: #/day _____

- ☐ Alcohol

Wine: #glasses/ day/week _____

Liquor: #ounces/ day/week_____

Beer: #glasses/ day/week _____

- ☐ Caffeine:

Coffee: #6 oz cups/day _____

Tea: #6 oz cups/day ______

Soda: w/caffeine: #cans/day ___

Other sources ______________

- ☐ Water: #glasses/day _______

Exercise

- ☐ 5-7 days per week
- ☐ 3 – 4 days per week
- ☐ 1-2 per week
- ☐ 45 mins or more duration per workout
- ☐ 30-45 mins duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

- ☐ Dairy
- ☐ Soy
- ☐ Wheat
- ☐ Eggs
- ☐ Corn
- ☐ All gluten
- ☐ Other ______________

Food Frequency

Servings per day:

Fruit (citrus, melons, etc.) ________

Dark green or deep yellow/orange vegetables ______________

Grains (unprocessed) ___________

Beans, peas, legumes ___________

Dairy, eggs ______________

Meat, poultry, fish ____________

Eating habits

- ☐ Skip breakfast
- ☐ Two meals a day
- ☐ One meal a day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally, eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source __________
- ☐ Magnesium
- ☐ Zinc
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs-teas
- ☐ Herbs-extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Others __________________

Minerals, describe

____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)