Carolina Holistic Health, LLC 201 West Stone Ave. Greenville, SC 29609

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

Name: ______________________ Today's Date: __________

Address: ______________________ Time: __________

Phone#: ______________________

Mobile #: ______________________ Date of Birth: __________

Email: ______________________ Height: __________ Weight: __________

Major Complaint(s) ______________________

Other Complaints: ______________________

Date of onset (when you first noticed your problem)? __________

Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

Have you had this in the past? ☐ No ☐ Yes When: __________

What makes it better? __________

What makes it worse? __________

Is your condition: ☐ Getting Worse ☐ Comes and Goes ☐ Constant

Medications/Drugs/Herbs you are currently taking: __________

List Surgeries/Operations you have had and dates: __________

Date of your last physical examination: __________ By whom: __________

MEDICAL HISTORY: (Do you have or have you ever had): ☐ Arthritis ☐ Asthma ☐ Anemia ☐ High Blood Pressure

☐ Cancer ☐ Heart trouble ☐ Hepatitis ☐ Jaundice ☐ Ulcers ☐ Gallstones

☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble

☐ Sudden weight gain ☐ Sudden weight loss ☐ Chronic Fatigue

FAMILY HISTORY: (Has any member of your family had any of the above)? ☐ No ☐ Yes

If yes, which member and what did they have? __________

ENERGY LEVEL: ☐ High (Time of day) __________ ☐ Low (Time of day) __________

STRESS: ☐ None ☐ Moderate ☐ Severe What causes it? __________

SWEATING: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating __________

CIRCULATION: Feelings of ☐ Hot ☐ Cold What area? __________

☐ Bleed easily ☐ Cold limbs ☐ Other: __________

SKIN: ☐ Dry ☐ Itchy ☐ Moist/clammy ☐ Burning ☐ Boils ☐ Bruises easily (black and blue spots)

☐ Acne ☐ Hair loss/thinning ☐ Dry scalp ☐ Frequent skin rashes ☐ Skin puffy/wrinkled

☐ Hives ☐ Changing moles or lumps (cysts/tumors) Other:

SCARS: (List all from accidents or surgeries) __________

SLEEP PROBLEMS: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming

Number of hours sleep each night: __________ ☐ Other __________

HEAD: ☐ Headaches (where) __________ ☐ Dizziness ☐ Memory loss ☐ Loss of balance

Other: __________

EYES: ☐ Eye pain ☐ Dry eyes ☐ Blurred vision ☐ Darkness under eyes

☐ Other: __________

EARS: ☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections ☐ Ringing/buzzing in ears

☐ Other: __________

NOSE: ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds

☐ Other __________

THROAT: ☐ Sore Throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Jaw problems

☐ Teeth/gum problems ☐ Swollen tongue ☐ Other

CHEST: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Mucus rattles when breathing
☐ Trouble breathing at night ☐ Pain/pressure in chest ☐ Palpitations ☐ Persistent cough
☐ Coughing blood ☐ Coughing phlegm ☐ Sputum color ☐ Consistency
☐ Other ____________________

BLOOD PRESSURE: ☐ High ☐ Low ☐ Normal ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black Stools ☐ Colon problems
☐ Mucus in stools ☐ Lower bowel gas ☐ Stools have foul odor ☐ Hemorrhoids
☐ Number of bowelmovements a day ____________ Other ____________________

URINE: Color __________ Amount __________ ☐ Frequent urination ☐ Daytime ☐ At night
☐ Strong smelling urine ☐ Hard to urinate ☐ Water retention
☐ Pain or burning on urinating ☐ Blood in urine ☐ Frequent infections
☐ Other ____________________

MUSCULOSKELETAL: Pain in ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Arms/hands
☐ Upper Back ☐ Mid Back ☐ Fingers ☐ Big toe ☐ Hip ☐ Knee
☐ Lower Back ☐ Bones sore/painful ☐ Loss of grip ☐ Swollen knees/elbows ☐ Leg cramps at night
☐ Weak ankles ☐ Weakness in legs ☐ Stiff all over ☐ Tingling in feet ☐ Muscle spasm/cramps
☐ Loss of feeling in hands/feet ☐ Painful joints ☐ Bursitis ☐ Other ____________________

NEUROLOGICAL: ☐ Nervousness ☐ Depressed ☐ Easily angered ☐ Easily irritated ☐ Frequent crying
☐ Worry/Anxiety ☐ Mood swings ☐ Memory confusion ☐ Poor concentration ☐ Suicidal
☐ Tremors ☐ Numbness/tingling in limbs ☐ Poor coodination ☐ Muscle weakness
☐ Feel weak and shaky ☐ Seizures ☐ Neuralgia (nerve pain) ☐ Shingles
☐ Other ____________________

FEMALES: ☐ Pregnant? Yes No Last Monthly period __________ Last PAP test __________

Form of birth control: None Pill Other ____________________
Menstrual Cycle: ☐ Low backache ☐ Painful ☐ Irregular ☐ Clotting ☐ Heavy Bleeding
Age started __________ Age Ended __________ ☐ Light scanty bleeding ☐ Color
☐ Miss periods ☐ Water retention ☐ Low or no sexual drive ☐ Mood changes ☐ Painful breasts
☐ Hot flashes ☐ Food cravings ☐ Other
Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid
Other ____________________

No. Pregnancies __________ No. Deliveries __________ No. Miscarriages __________ No. Abortions __________
No. Cesareans __________ Operations: ☐ Cervix ☐ Uterus ☐ Ovaries
Other ____________________

MALES: ☐ Impotence ☐ Low or no sexual drive ☐ Ejaculation causes pain ☐ Discharges
☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostate trouble
Other ____________________

APPETITE: ☐ Poor appetite ☐ Excessive appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed
☐ Never thirsty ☐ Excessive thirst Other ____________________
☐ Specific food cravings? Yes No If yes, what? ____________________

DIGESTION: ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ Burning/belching ☐ Stomach pain
☐ Nausea ☐ Stomach cramps ☐ Vomiting ☐ Abdominal bloating How long after eating?
☐ Weight gain ☐ Weight loss ☐ Sores in mouth ☐ Bad breath ☐ Bitter/sour taste in mouth

Food allergies? Yes No If yes, to what? ____________________

NUTRITION: List some of your favorite foods ____________________

Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

How many meals a day do you eat? __________ When is your biggest meal? __________

Do you eat when you are worried or rushed? Yes No How often? __________

Do you plan your meals according to the "Four basic food groups"? Yes No

How many glasses of water do you drink a day? __________ ☐ Filtered ☐ Bottled

Do you use alcohol? ☐ Yes ☐ No Drinks per day __________ Drinks per week __________

Do you use tobacco? ☐ Yes ☐ No Packs per day __________ How many years __________

Eat raw fruits or vegetables at least twice a day? Yes No
Eat between meals? Yes No
Chew your food thoroughly before swallowing? Yes No
Always add salt at the table? Yes No
Eat meat or dairy 2 or more times a day? Yes No
Eat the same foods every day? Yes No
Eat when you are not hungry? Yes No
Occasionally go on a crash diet? Yes No