

Patient Name: _____

Date: _____

Your Past Medical History (please indicate with date(s):

Cancer _____ High Blood Pressure _____ Rheumatic Fever _____ Venereal Disease _____
 Diabetes _____ Heart Disease _____ Seizures _____ Asthma _____
 Hepatitis _____ Stroke _____ Thyroid Disease _____ Pacemaker _____
 Other: _____

Surgeries (type and date): _____

Significant Trauma (auto accidents, falls, etc.): _____

Significant Dental Work (type and date): _____

Birth History (prolonged labor, forceps delivery, caesarian section, other): _____

(How) Do You Take Care Of Your Spirit? _____

Family Medical History (other family members besides yourself):

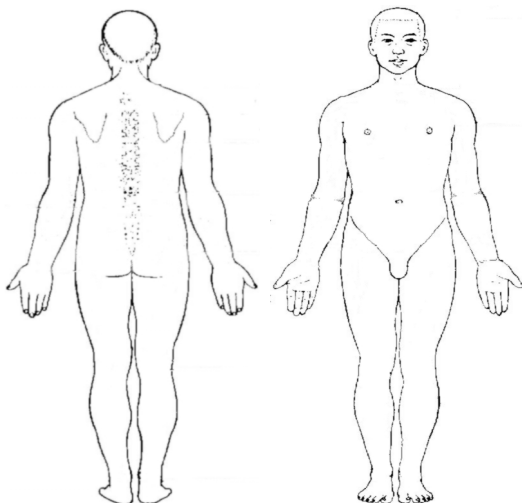
High Blood Pressure Alcoholism Cancer: _____ Allergies (other family): _____
 Heart Disease Seizures _____
 Arteriosclerosis Asthma _____
 Stroke Diabetes _____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you exercise regularly? Y or N Please describe: _____

Comments (please list any other problems you would like to discuss): _____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past 2 weeks.

General

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold / hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
Time of day: _____
- Edema
Where: _____
- Poor sleeping
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight change
Gain / Loss _____

Skin and Hair

- Rashes
 - Itching
 - Change in hair or skin
 - Ulcerations
 - Eczema
 - Oozing skin lesion
 - Hives
 - Pimples
 - Recent moles
 - Loss of hair
 - Dandruff
- Other hair or skin problems*

**Head, Eyes, Ears
Nose, and Throat**

- Dizziness
- Migraines
- Headaches
When: _____
Where: _____
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision

- Color blindness
 - Blind field
 - Spots in front of eyes
 - Eye pain
 - Eye strain
 - Cataracts
 - Eye Dryness
 - Excessive tearing
 - Discharge from eyes
 - Poor hearing
 - Ringing in ears
 - Earaches
 - Discharge from ear
 - Nose bleeds
 - Sinus congestion
 - Nasal drainage
 - Grinding teeth
 - Teeth problems
 - Jaw clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips/tongue
- Other head / neck problems*

Cardiovascular

- High blood pressure
 - Low blood pressure
 - Chest discomfort/pain
 - Heart palpitations
 - Cold hands or feet
 - Swelling of hands
 - Swelling of feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart/blood vessel problems:* _____

Respiratory

- Cough
 - Asthma/wheezing
 - Difficulty in breathing when lying down
 - Phlegm *Color? _____*
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems:* _____

Gastrointestinal

- Bad breath
 - Nausea
 - Vomiting
 - Heartburn
 - Belching
 - Indigestion
 - Diarrhea
 - Constipation
 - Chronic laxative use
 - Blood in stools
 - Black stools
 - Abdominal pain/cramps
 - Gas
 - Rectal pain
 - Hemorrhoids
- Other stomach or intestinal problems:* _____

Genito-Urinary

- Pain on urination
 - Urgency to urinate
 - Frequent urination
 - Blood in urine
 - Decrease in flow
 - Dribbling
 - Kidney stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Do you wake to urinate?**
 Yes No
- How often?* _____
What color is your urine?

- Other genital or urinary system problems?* _____

**Pregnancy and
Gynecology**

- # of pregnancies:* _____
- # of births:* _____
- # premature births:* _____
- # of miscarriages:* _____
- # of abortions:* _____
- Age at first menses:* _____
- Length of full cycle:* _____
- Length of menses:* _____
- Last menses start date:* _____

- Heavy periods
 - Light periods
 - Painful periods
 - Irregular periods
 - Changes in body/psyche prior to menstruation
 - Clots
 - Vaginal discharge:
 - Menopause:
Age: _____
Year: _____
 - Postcoital bleeding
 - Vaginal sores
 - Breast lumps
 - Nipple discharge
- Do you practice birth control?*
 Yes No
- What type and for how long?*

Musculoskeletal

- Neck pain
 - Shoulder pain
 - Back pain
 - Elbow pain
 - Hand/wrist pain
 - Hip pain
 - Knee pain
 - Foot/ankle pain
 - Muscle pain
 - Muscle weakness
- Other pain?* _____

Neuropsychological

- Seizures
 - Areas of numbness
 - Weakness
 - Sleep disorder
 - Concussion
 - Violence potential
 - Vertigo
 - Lack of coordination
 - Bad temper
 - Depression
 - Easily stressed
 - Loss of balance
 - Poor memory
 - Anxiety
 - Substance abuse
- Have you ever been treated for emotional problems?*
 Yes No

Patient Name: _____

Date: _____

Last Physical Date: _____ Doctor: _____ Results: _____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diet Please give a general description of the food you eat during a "typical" day.

Morning:

Afternoon:

Evening:

Before bed:

Between meals:

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

What medicines have you taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

What allergies do you have? What reactions do you have to these chemicals, foods, drugs, animals etc?

Local person to call in case of an emergency? Relative, friend, neighbor? _____