Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_ Number of Children\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:  Single Married  Partner  Separated  Divorced  Widow

 Are you pregnant?\_\_\_\_ Date \_\_\_\_\_\_\_\_ Are you recovering from a cold or flu? \_\_\_\_ Date Began\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for office visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laboratory Procedures Performed (e.g., stool analysis, blood and urine chemistries, hair analysis)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outcome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of therapy have you tried for this problem(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diet Modification  Fasting  Vitamin/Mineral  Herbs  Homeopathy

 Acupuncture  Conventional Drugs  Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication (Prescriptions or Over-The-Counter):

|  |  |  |
| --- | --- | --- |
| Name | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |

Major Hospitalizations, Surgeries, Injuries: Please List All Procedures, Complications (if any) and Dates:

|  |  |  |
| --- | --- | --- |
| Year | Operation, Illness, Injury | Outcome |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider yourself:  Underweight  Overweight  Just right  Unintentional weight loss or gain of 10 pounds or more in the last three months. Your weight today \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)

 Corrective Lenses  Dentures  Hearing Aid  Medical Devices/Prosthetics/Implants

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any recent changes in your ability to:
 See  Hear Smell  Feel Hot/Cold Sensations  Move Around

Do you have any strong like for any of the following flavors:
 Sour  Bitter Sweet  Rich/Fatty  Spicy/Pungent Salty

Do you have any strong dislike for any of the following flavors:
 Sour Bitter  Sweet  Rich/Fatty  Spicy/Pungent  Salty

Do you prefer: Warmth (i.e., food, drinks, weather, etc.) yes  Cold (i.e., food, drinks, weather, etc.)

Is your sleep disturbed at the same time each night? \_\_\_yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, what time? \_\_\_\_3am\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of day you feel the most energy or least symptoms:
 7 a.m. – 9 a.m. 9 a.m. – 11 a.m.  11 a.m. – 1 p.m.  1 p.m. – 3 p.m.  3 p.m. – 5 p.m.  5 p.m. – 7 p.m.
 7 p.m. – 9 p.m.  9 p.m. – 11 p.m.  11 p.m. – 1 a.m.  1 a.m. – 3 p.m.  3 a.m. – 5 a.m.  5 a.m. – 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:
 7 a.m. – 9 a.m.  9 a.m. – 11 a.m.  11 a.m. – 1 p.m.  1 p.m. – 3 p.m.  3 p.m. – 5 p.m.  5 p.m. – 7 p.m.
 7 p.m. – 9 p.m.  9 p.m. – 11 p.m.  11 p.m. – 1 a.m.  1 a.m. – 3 p.m.  3 a.m. – 5 a.m.  5 a.m. – 7 a.m.

Do you experience any of these general symptoms EVERYDAY?
 Debilitating Fatigue  Short of Breath  Insomnia  Constipation  Chronic Pain/Inflammation
 Depression  Panic Attack  Nausea  Fecal Incontinence  Bleeding
 Disinterest in Sex  Headaches  Vomiting  Urinary Incontinence  Discharge
 Disinterest in Eating  Dizziness  Diarrhea  Low Grade Fever  Itching/Rash

|  |  |  |
| --- | --- | --- |
| **Medical History**Past Present  Arthritis  Allergies/Hay fever  Asthma  Alzheimer’s Disease  Autoimmune Disease  Blood Pressure Problems  Bronchitis  Cancer Chronic Fatigue Syndrome  Carpal Tunnel Syndrome  Cholesterol, Elevated  Circulatory Problems  Colitis**Medical History**Past Present  Sinus Problems  Stroke  Thyroid Problems  Obesity  Osteoporosis  Pneumonia  Sexually Transmitted Disease  Seasonal Affective Disorder  Skin Problems  Tuberculosis  Ulcer  Urinary Tract Infection  Varicose Veins  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medical (Men)**Past Present  BPS  Prostate Cancer  Decreased Sex Drive  STD  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medical (Women)**  Menstrual Irregularities  Endometriosis  Infertility  Fibrocystic Breasts  Fibroids / Ovarian Cysts  PMS  Fibrocystic Breasts  Fibroids / Ovarian Cysts  Breast Cancer  Pelvic Inflammatory Disease  Vaginal Infections  Decreased Sex Drive  STD  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Past Present  Dental Problems  Depression  Diabetes   Diverticular Disease  Drug Addiction  Eating Disorder  Epilepsy  Emphysema Eyes, Ears, Nose Throat  Environmental Sensitivity  Fibromyalgia Food Intolerant  Gastroesophageal Reflux**Medical (Women, cont.)**Age of First Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Gynecological Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mammogram  +  - PAP  +  - Form of Birth Control# of Children \_\_\_\_\_\_ # of Pregnancy\_\_\_\_\_ C-Section \_\_\_\_\_\_\_\_\_\_\_\_\_\_  MenopauseDate of Last Menstrual Cycle \_\_\_\_\_\_\_\_\_\_\_\_\_Length of Cycle \_\_\_\_ Days\_\_\_\_\_ Interval Time Between Cycles \_\_\_\_\_\_ DaysAny Recent Change in Normal Menstrual Flow (Heavier, Large Clots, Scanty) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Family Health History** Arthritis, Rheumatoid Asthma Alcoholism Alzheimer’s Disease Cancer Depression Diabetes  Drug Addiction  Eating Disorder Genetic Disorder Glaucoma Heart Disease Infertility Learning Disabilities Mental Illness Mental RetardationMigraine Headaches Obesity Osteoporosis Neurological Disorder Stroke  Suicide Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Health Habits**Past Present  TobaccoCigarette #/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_Cigar #/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alcohol | Past Present  Genetic Disorder  Heart Disease  Infection, Chronic  Inflammatory Bowel Disease  Kidney or Bladder Disease  Learning Disabilities  Liver or Gallbladder Disease  Mental Illness  Mental Retardation  Glaucoma  Gout  Migraine Headaches  Neurological Problems**Health Habits (cont.)**Wine #/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Liquor #/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Beer #/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Past Present CaffeineWine # 6 oz cups/day \_\_\_\_\_\_\_\_\_\_\_\_\_Coffee # 6 oz cups/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tea # 6 oz cups/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soda /w Caffeine # 6 oz cup/Day \_\_\_\_Other Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Water # glasses/day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Exercises** 5 - 7 day per week 3 - 4 day per week 1 - 2 day per week 45 min or more per workout 30-45 min per workout Less than 30 minutes Walk Run, walk, jump rope Weight, lift Swim Yoga Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Nutrition & Diet** Mixed food diet (veg and meat) Mixed food diet (veg, no red meat) Vegetarian Vegan Salt restriction Fat restriction Starch/carb restriction Total calorie restriction Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specific food restriction Dairy  Wheat  Eggs Soy  Corn Gluten Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Nutrition & Diet**Serving per day:Fruits (citrus, melon) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dark green or deep yellow/orange vegetables \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grains (unprocessed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Beans, peas, legumes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Serving per day:Dairy, eggs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Meat, poultry, fish\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Eating Habits** Skip breakfast Two meal/day One meal/dayGraze (small, frequent meals) Food rotation Eat constantly Generally eat on the run Add salt to food**Current Supplement** Vitamin C Vitamin E EPA, DHA Evening Primrose/GLA Calcium, source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friendly Flora (acidophilus) Digestive Enzymes Amino Acids CoQ10 Antioxidants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Multivitamin/mineral Herb – Tea Herb – Extract Chinese Herbs Ayurvedic Herbs | **Current Supplement (Continued)** Homeopathy Bach Flowers Protein Shakes Superfoods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Liquid meal (i.e., Ensure)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**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, focused Improve memory | **Would you like to:** Do better on tests in school Not be dependent on drugs Stop using laxatives/softeners Be free of pain Sleep better Have agreeable breath Have agreeable body odor Have stronger teeth Get fewer colds/flus Get rid of allergies Reduce risk of inherited disease tendencies (i.e., cancer, heart disease, etc.)**Any other concerns:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please mark an “X” to indicate areas where you feel pain, swelling, or discomfort, or area of your skin that have change color or texture (i.e., moles, rashes, etc.). Describe what you feel or observe in your own words.

