PATIENT History

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Name: _____ Date:

Age: _____ Birthdate: _____ Sex: ____ Marital Status: _____ Height: _____ Weight: _____

Occupation: _____ Years: _____

Spouse's Name/Occupation: _____ Years: _____

Who referred you to this office? _____

Main Reason for This Visit: _____

Known Diagnoses or Health Problems:

_____

_____

_____

_____

Personal Health Goals:

_____

_____

_____

_____

Previous/Present Doctor: _____ _____

Other practitioners involved in your care (Please list, including specialty):

_____

_____

_____

Past Medical History (Please list or describe):

Year/Date

Operations or surgery: _____

_____

_____

_____

Accidents: _____

_____

_____

Broken Bones: _____

_____

Year/Date

Head Injury: _____

Hospitalizations: _____

_____

_____

Serious Illnesses: _____

_____

_____

Blood Transfusions: _____

Pacemaker: _____

Medications, Allergies, and Sensitivities

Please list any medications or drugs, and any foods or other substances to which you are allergic:

Are you or have you been exposed to any of the following?

Chemicals____ radiation____ paints____ fumes____ dust____ solvents____ unpurified water_____

Travel to 3rd world country____ wilderness areas____ other_____

Number of courses of antibiotics: Less than 5____ 5-10____ More than 10____

Courses of steroids (how many): _____

List all medications you are taking (including over the counter meds and birth control pills – past or current):

Name: Dose: Frequency:

_____

_____

_____

_____

_____

List any vitamin, herb, or supplements you are taking:

Name: Dose: Frequency:

_____

_____

_____

_____

_____

FAMILY History

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Please list the health of your family members as Excellent, Good, Fair, or Poor. Indicate if they have any of the following: allergies or asthma, anemia, arthritis, bleeding tendencies, cancer or tumor, colitis, depression, diabetes, drug or alcohol abuse, epilepsy, glaucoma, heart disease, high-blood pressure, immunologic disease, kidney or bladder trouble, liver disease, mental illness, migraines, obesity, osteoporosis, stomach issues, stroke, TB, other. If deceased, please list the cause and at what age they passed.

Father: _____

Mother: _____

Brothers/Sisters (please indicate sex): _____

_____

_____

Children (please indicate sex): _____

_____

_____

Grandparents: _____

_____

Other Relatives: _____

_____

Health Habits (Check Yes or No and circle day or week)

Tobacco smoking	☐ Yes ☐ No	_____ packs per day / week	Type of tobacco _____	
Coffee	☐ Yes ☐ No	_____ cups per day / week	☐ Reg	☐ Decaf
Tea	☐ Yes ☐ No	_____ cups per day / week	☐ Reg	☐ Herbal
Alcohol	☐ Yes ☐ No	_____ drinks per day / week	☐ Wine	☐ Beer ☐ Liquor
Soft drinks	☐ Yes ☐ No	_____ drinks per day / week	☐ Regular	☐ Diet
Artificial Sweeteners	☐ Yes ☐ No	_____ packs per day / week		

Glasses water/fluid per day _____ plain water _____ juice _____ other

What exercises/activities do you do and how often? _____

How many hours of sleep do you get per night? _____ Is it restful? _____

Do you have an adequate energy level? _____

Mark the stress level in your life (0 is the least, 10 is the most): 1 2 3 4 5 6 7 8 9 10

How much does stress affect you (0 is the least, 10 is the most)? 1 2 3 4 5 6 7 8 9 10

What is your job satisfaction (0 is the least, 10 is the most)? 1 2 3 4 5 6 7 8 9 10

What are the major stresses in your life presently? _____

How many hours per week do you work? _____ How many hours per week do you have for free time? _____

Favorite pastime/recreational activity:

Tests and Immunizations (Mark an X next to those you have had.

Year		Year		Year	
_____	☐ Chest X-ray	_____	☐ Other X-rays	_____	☐ Tetanus "shot"
_____	☐ Kidney X-ray	_____	☐ TB test	_____	☐ Flu injection
_____	☐ G.I. series	_____	☐ Electrocardiogram	_____	☐ Pneumovax injection
_____	☐ Colon X-ray	_____	☐ MRI or CAT-SCAN	_____	☐ Ubella injection
_____	☐ Back X-ray	_____	☐ Treadmill or Stress-EKG	_____	☐ Other injection

Health Maintenance:

_____	☐ Last check-up	_____	☐ Rectal exam	_____	☐ Mammogram
_____	☐ Cholesterol test	_____	☐ Stool blood test	_____	☐ Pap smear
_____	☐ Blood tests	_____	☐ SIgmoidoscopy	_____	☐ Bone density test

SYMPTOMS – sheet A

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Have you ever had any of the following? Please indicate "C" for current and "P" for past:

GENERAL
___Fever, chills, sweats
___ Night sweats
___ Fatigue
___ Nervousness/anxiety
___ Irritability
___ Depression
___ Generally feel "run down"
___ Sexual abuse (optional)
___ Emotional abuse (optional)
___ Loss of weight

SKIN
___ Non-healing sore
___ Hives, rash
___ Eczema, psoriasis
___ Frequent infection or boils
___ Abnormal pigmentations, moles
___ Warts
___ Herpes:
  ___ lips
  ___ genital
  ___ zoster (shingles)
___ Skin cancer or melanoma
___ Brittle or weak nails
___ Infected nails

ENDOCRINE
___ Diabetes
___ Thyroid disease
___ Heat or cold intolerance
___ Dry skin
___ Change in hair growth or texture
___ Excessive thirst or urination
___ Sexual problems
___ Hormone therapy
___ Low or high sex drive
___ Radiation to neck or face area
___ Low blood sugar

HEAD-EYES-EARS-NOSE-THROAT
___ Headache
___ sinus (allergy)
___ tension
___ migraine
___ Head feels "heavy"
___ Loss of memory
___ Light-headedness or "spaciness"
___ Light bothers eyes
___ Eye disease or injury
___ Blurry vision
___ Double vision
___ Loss of vision
___ Glaucoma, cataracts
___ Loss of balance
___ Dizziness or vertigo
___ Loss of hearing
___ Ear disease
___ Impaired hearing
___ Ringing/buzzing in ears
___ Ear pain
___ Discharge from ear
___ Runny nose or nasal discharge
___ Nosebleeds
___ Chronic sinus trouble
___ Snoring
___ Sore throats
___ Hoarseness
___ Tooth & gum problems
___ Loss of taste
___ Sores in mouth
___ Sore tongue

RESPIRATORY
___ Frequent "colds"
___ Difficulty breathing
___ Chronic or frequent cough
___ Asthma or wheezing
___ Emphysema
___ Spitting up blood
___ Pleurisy (pain with breathing)
___ Pneumonia
___ Coughing up sputum

CARDIOVASCULAR
___ High blood pressure
___ Palpitation, irregular heart beat
___ Rheumatic fever
___ Chest pain or angina
___ Shortness of breath with walking
___ Shortness of breath lying down
___ Difficulty walking two blocks
___ Heart trouble
___ Heart attack
___ Heart murmur
___ Awakening in night smothering
___ Swelling of hands, feet or ankles
___ Need more than 1 pillow to sleep
___ Calf pain walking relieved by rest
___ Varicose veins

HEMATOLOGIC
___ Excessive bleeding/bruising
___ Anemia
___ Phlebitis/blood clots in veins
___ Are you slow to heal after cuts or bruising?
___ Difficulty w/bleeding excessively after tooth extraction or surgery
___ Mononucleosis

GASTROINTESTINAL
___ Painful bowel movement
___ Vomiting blood or food
___ Heartburn/indigestion
___ Food sticks in throat
___ Difficulty swallowing
___ Diarrhea or loose stools
___ Ulcer (stomach or duodenal)
___ Gallbladder disease or stones
___ Liver trouble/hepatitis
___ Bloody or black stools
___ Constipation
___ "Nervous" stomach
___ Nausea and/or vomiting
___ Bloating in stomach after eating
___ Bloating or gas in lower abdomen
___ Thin or ribbon like stools
___ Hard/difficult bowel movements

GENITOURINARY
___ Frequent urination
___ Involuntary loss of urine
___ Burning or painful urination
___ Blood in urine
___ Straining to urinate
___ Hernia
___ Sexually transmitted disease
___ Kidney stones
___ Kidney infections

FEMALE
___ Last menstrual period_____date
___ Currently pregnant
___ Age periods started
___ Duration of flow ____ days
___ Days in cycle _____ days
___ Pelvic pain or infection
___ Excess discharge
___ Excess discharge
___ PMS
___ Menstrual cramping
___ Irregular cycle
___ Number of pregnancies
___ Number of children
___ Number of ectopic pregnancies
___ Number of miscarriages
___ Number of abortions
___ DES exposure
___ Uterine fibroids
___ Hysterectomy
___ Date of menopause _____
___ Hot flashes
___ Menopausal bleeding
___ Breast pain
___ Breast lumps
___ Nipple discharge or bleeding
___ Abnormal PAP smear

MALE
___Testicular pain/swelling
___ Urinary frequency or burning
___ Difficulty in starting stream of urine
___ Discharge from penis
___ Frequent night urination
___ Prostate pain/swelling
___ Undescended testicle
___ Impotence

LOCOMOTOR-MUSCULOSKELETAL
___ Joint swelling
___ Arthritis or joint pain
___Weakness of muscles or joints
___ Back pain (see next page)
___ Difficulty walking
___ Leg cramps
___ Leg ulcers

MENTAL EMOTIONAL/NEUROLOGIC
___ Fainting spells
___ Epilepsy/Seizures
___ Stroke or mini-stroke
___ Paralysis
___Weakness of an arm or leg
___ Insomnia or trouble sleeping

Tendency towards:
___ Sadness/grief/depression
___ Anger/irritability
___ Anxiety/fear
___ Mental overactivity

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SYMPTOMS – sheet B

NECK
___ Pain
Neck pain with movement:
___ forward
___ backward
___ turning to the left
___ turning to the right
___ bending to the left
___ bending to the right
___ Pinched nerve in neck
___ Neck feels out of place
___ Muscle spasms in neck
___ Grinding sounds in neck
___ Popping sounds in neck
___ Arthritis in neck
___ Swollen glands

SHOULDERS
___ Pain in shoulder joint (R / L)
___ Pain across shoulders
___ Bursitis (R / L)
___ Arthritis (R / L)
___ Can't raise arm:
___ above shoulder level
___ over head
___ Can't put arm behind back
(as if putting on a bra)
___ Tension in shoulders
___ Pinched nerve in shoulder (R / L)
___ Muscle spasms in shoulders

ARMS AND HANDS
___ Pain in upper arm (R / L)
___ Pain in elbow (R / L)
___ Movement aggravates pain
___ Pain in forearm (R / L)
___ Pain in hands (R / L)

___ Pain in fingers (R / L)
___ Feeling of pins & needles in arms (R / L)
___ Feeling of pins & needles in fingers (R / L)
___ Numbness in arms (R / L)
___ Numbness in fingers (R / L)
___ Fingers go to sleep (R / L)
___ Hands cold (R / L)
___ Swollen joints in fingers (R / L)
___ Arthritis in fingers (R / L)
___ Loss of grip strength (R / L)

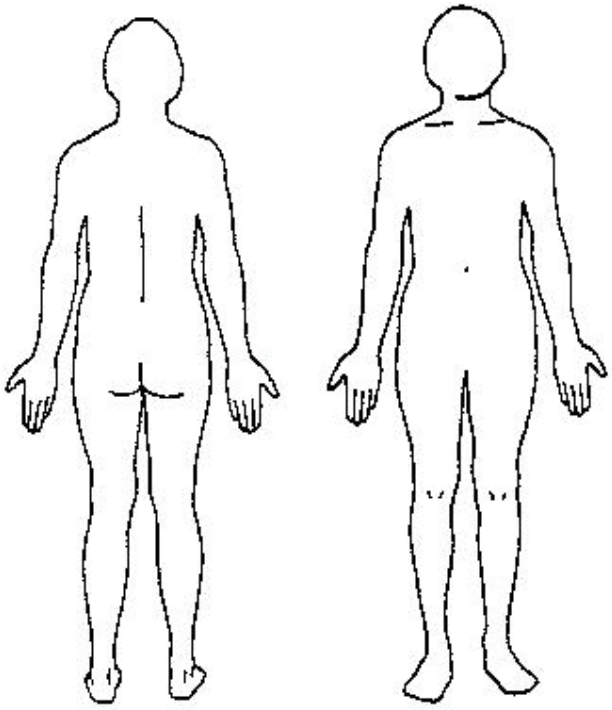
MID-BACK & CHEST
___ Mid-back pain
___ Pain between shoulder blades
___ Sharp stabbing pain
___ Dull ache
___ Pain from front to back
___ Muscle spasms in mid back
___ Pain in kidney area
___ Chest pain
___ Shortness of breath
___ Pain around ribs

LOW BACK
___ Low back pain
___ Upper lumbar
___ Lower lumbar
___ Sacroiliac pain
Low back pain is worse when:
___ working
___ lifting
___ stooping
___ standing
___ sitting
___ bending
___ coughing
___ lying down (sleeping)
___ walking
___ other
Pain relieved with:
___ ice
___ heat
___ movement
___ physical therapy
___ topical analgesics
___ medications
___ other
___ Slipped disk
___ Low back feels out of place
___ Muscle Spasms

HIPS, LEGS, AND FEET
___ Pain in buttocks (R / L)
___ Pain in hip joint (R / L)
___ Pain down leg (R / L)
___ Pain down both legs
___ Knee pain (R / L)
___ Leg cramps (R / L)
___ Cramps in feet (R / L)
___ Pins & needles in legs (R / L)
___ Numbness of leg (R / L)
___ Numbness of feet (R / L)
___ Numbness of toes (R / L)
___ Feet feel cold (R/L)
___ Swollen ankles (R / L)
___ Swollen feet (R / L)

THERAPEUTIC TECHNIQUES
___ Acupuncture
___ Herbal Medicine
___ Homeopathy/Bach Flower
___ Hellerwork
___ Rolfing/Structural intergration
___ Massage
___ Chiropractic
___ Psychotherapy (Optional)
___ Visualization/Guided Imagery
___ Biofeedback
___ Feldenkrais
___ Polarity
___ Reiki
___ Tragerwork
___ Craniosacral Therapy
___ Physical Therapy
___ Therapeutic Exercise
___ Movement Therapy
___ Nutrition
___ Other _____

Please indicate where you have pain by shading the areas in the outlines below.



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DIET Diary

Please list everything you eat or drink for three full days:

	Day One	Day Two	Day Three
Breakfast:			
Lunch:			
Dinner:			
Snacks:			

How many times a week do you eat in a restaurant? ____ Breakfast ____ Lunch ___ Dinner

What type of restaurants? _____

Favorite foods? _____

Foods you dislike? _____

Do you crave sweets? _____ When? _____

Do you salt your food? _____ Before or after tasting? _____

Presently, are you on any specific type of diet? _____

Do you feel good about your body and your current weight? _____

Would you like to decrease or increase your weight? _____

When did you last have a significant weight change? _____

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TIMELINE

Please write out a brief timeline, in outline form, of your own history. Beginning with birth or early childhood, include major illness, injuries or hospitalizations, significant turning points or major events in your life, any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. For women, please include events related to your reproductive system (first period, pregnancies, abortions, birth control, menopause, etc.). If you are filling this out for your child, please include any notable information about the pregnancy and nursing. Again, keep it brief and simple; we will go into detail as needed.

Birth:

Childhood:

Teen Years:

Adult Years:

Middle Years:

Senior Years: