Today's date ________________________

First Name______________________________ Middle Initial_________ Last_______________________________

Phone (H) ____________________ (C) ____________________ (W) ____________________

Address __________________________________ City _______________ State ______ Zip __________

Age ________ Date of Birth _______________ Email address__________________________________

Height _________ Weight __________ Marital Relationship/Status _____________ SS # ______________________

Occupation, Employer Name, & Address____

Family Physician _______________________________ Referred By _________________________________

Emergency Contact ____ Phone______________________

Email Address ____

Primary Reason for visit ____

____

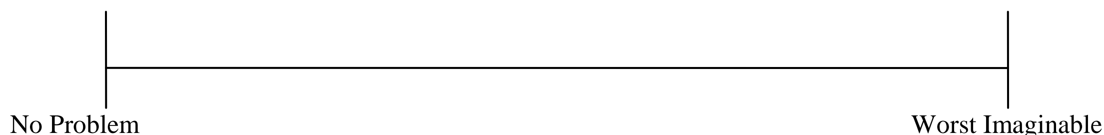
How long ago did this problem begin (be specific)? ____

Have you been given a diagnosis for this problem: If so, what? _____________________________________

What kinds of treatment have you tried? ____

What provides relief? __________________________ Makes it worse? ______________________________________

Please note the severity of your problem:



No Problem Worst Imaginable

Medical History (check any that apply): Bleeding disorder ☐ Pace Maker ☐ Blood Thinning Medication ☐ Pregnancy ☐

Past Medical History (please include date): Cancer_____ Diabetes_____ Hepatitis_____ HIV/AIDS______ Seizures_____

High or Low Blood Pressure_____ Heart Disease_____ Thyroid Disease_____ Venereal Disease____ Rheumatic Fever_____

Family Medical History (check): Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐

Surgeries/Significant Dental Work (type and date) ____

Significant Trauma (car accidents, falls, etc.) ____

Allergies (drugs, chemicals, foods) ____

Medicines and supplements taken within the last two months (vitamins, drugs, herbs, etc.)

____

Do you exercise regularly? Yes ☐ No ☐ What type of exercise? ____

Have you ever been on a **restricted diet**? Yes ☐ No ☐ What Kind? ____

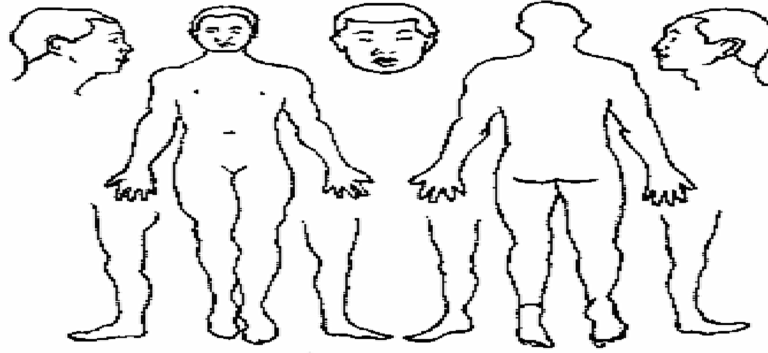
Please describe your **average daily diet**:

Morning________________________Afternoon_________________________Evening______________________________

Number of cigarettes smoked per day: ________ cups of C**offee, tea, or soft drinks** consumed per day:___________

Glasses/type of **Alcohol** consumed per week: ________________ Recreational drugs used: _______________________

Please mark painful or distressed areas:



Please check any you have had in the last three months:

General
- Poor appetite Sweat easily
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, but no desire to drink
- Sudden energy drop

When? ________________
- Poor sleep Hard to fall asleep
- Wake at night

What time? ________________
- Night sweats Fatigue
- Poor balance
- Cravings for __________
- Weight gain Weight loss

Skin and Hair
- Eczema Itching
- Loss of Hair
- Other problems with skin and hair: ________________________

Head, Eyes, Ears, Nose, and Throat
- Dizziness
- Poor vision Blurry vision
- Ringing in ears
- Sinus problems
- Concussions
- Poor hearing
- Nose bleeds
- Spots in front of eyes
- Grinding teeth Jaw pain
- Eye pain Earaches
- Migraines/Headaches
- Other ENT problems: ______

Cardiovascular
- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots Chest pain
- Low blood pressure
- Swelling of hands or feet
- Fainting
- Difficulty in breathing
- Other cardiovascular problems: ____________

Respiratory
- Cough Bronchitis
- Difficulty in breathing when lying down
- Production of phlegm What color ____________
- Coughing blood
- Pneumonia Asthma
- Other lung problems: _____

Gastrointestinal

How often are your bowel movements? _________

Does stool sink or float? _____
- Mucus or Blood in stool
- Pain with stooling
- Nausea Constipation
- Diarrhea Acid Reflux
- Bad breath
- Gas Vomiting
- Abdominal pain or cramps
- Chronic laxative use
- Black stools/Blood in stools
- Hemorrhoids
- Other stomach or intestinal problems:_____________

Genito-urinary
- Pain with urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Wake up to urinate
- Blood in urine
- Kidney stones
- Sores on genitals
- Impotency
- Erectile dysfunction
- Other genito-urinary problems: _____________

Pregnancy and Gynecology

Number of pregnancies ____

Number of births _________

Number of children, ages _____

Miscarriages _____________

Abortions ______________

Age at first menses _______

Days between menses _____

Duration ________________

First day of last menses _______
- Heavy or light Absence
- Irregular periods
- Painful periods PMS
- Clots PCOS
- Vaginal discharge or itching
- Vaginal or pelvic pain
- Breast lumps Breast pain
- Last Pap _____________

Do you practice birth control?

Yes No

If yes, what type and for how long?

____

Do you use an IUD? ________
- Trouble getting pregnant

How long have you been trying?

____

Musculoskeletal
- Neck pain Shoulder pain
- Hip pain Back pain
- Hand/wrist pain
- Knee pain Foot/ankle pain
- Muscle pain
- Muscle weakness

Neurological and Psychological
- Areas of numbness Where ________________
- Bad temper or Irritability
- Depression Anxiety
- Easily susceptible to stress
- Other neurological or psychological problems: ______________________