

Patient Name: _____ Date of Birth _____ Date: _____

1. Tell us why you are here:

- For general health and well-being For a particular concern

Specify: _____

2. If you are here for pain, please describe:

a. Area of pain _____

b. Length of time you have had this pain _____

c. Diagnosis received _____

d. Do you recall any specific incident at the time of onset, or prior to onset of pain, that you feel is associated with your condition? _____

e. The pain is: Constant Intermittent Improving Worsening

f. Symptoms are worse in the: morning afternoon night increase or decrease during the day

g. The pain interferes with my:

Work Sleep Daily Routine Sexual Activity Recreation Other _____

h. Rate the pain on a scale of 1 to 10 (0 = no pain, 10 = worse possible pain) _____

i. Symptoms are: Sharp Dull Burning Aching Throbbing Numbness Tingling

j. Do your symptoms radiate? _____

k. Things that aggravate the pain: _____

l. Things that relieve the pain: _____

3. List health practitioners seen for this condition, treatments received, and effectiveness: _____

4. List previous surgeries (including cosmetic surgery): (Attach list if more than 5)

_____	Date	_____
_____	Date	_____
_____	Date	_____
_____	Date	_____
_____	Date	_____

5. Any other hospitalizations, accidents, injuries, broken bones or significant problems:

_____	Date	_____
_____	Date	_____
_____	Date	_____

6. Medical History: (Example: high cholesterol, diabetes, etc. Attach list if more than 4)

_____	Date	_____
_____	Date	_____
_____	Date	_____
_____	Date	_____

7. Drug/Food/Environmental Allergies _____ Latex Allergy: Y / N

8. Current medications **and doses**, including over the counter medications:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

9. List all supplements & brand:

1.	5.
2.	6.
3.	7.
4.	8.

10. Diet: Low Fat Gluten-Free Dairy-Free
 Regular (eats anything) Paleo / Ketogenic Vegetarian / Vegan
 Dining Out > 3 meals/week Other: _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snacks & Drinks: _____

Number of bowel movements per day/week: _____

11. Indicate approximate dates and the nature of any traumatic experience you have had. (e.g. death in family, divorce, change of residence, job loss, sexual assault, etc.)

_____	Date _____
_____	Date _____
_____	Date _____

12. Do you suffer from:

- Fatigue Sleep problems Irritability
- Moodiness or depression Appetite or weight changes Lack of enjoyment in life
- Memory problems Anxiety
- Compulsive behavior (e.g. binge eating, hand washing, checking locked doors, etc.)

13. Do you:

- a. Get along with people outside your family Yes No
- b. Feel isolated or lonely Yes No
- c. Have clear goals for direction in life Yes No
- d. Feel satisfied with your life Yes No

14. How many days of work have you missed in the past 4 weeks? _____

15. Review of Systems: Please check the box if currently or in the past any of the following symptoms have pertained to you. Do not include brief illnesses (colds, flus) from which you have recovered without complication.

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cough | <input type="checkbox"/> Skin rash or changing mole |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Breast lump/nipple discharge |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Skin cancer/precancer |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Emphysema/chronic bronchitis | <input type="checkbox"/> Other skin/breast/nail/hair concern or change |
| <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Tuberculosis exposure | <input type="checkbox"/> Rashes that come and go |
| <input type="checkbox"/> Chills | | <input type="checkbox"/> Acne |
| | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Eczema or psoriasis |
| <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Diarrhea or constipation | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blood or black tarry stool | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Migraine/recurrent headache |
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Pain in stomach/abdomen | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Heartburn/reflux/ulcer | <input type="checkbox"/> Stroke/mini-stroke |
| | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Sudden loss of ability to see, speak, walk, move |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Hepatitis/jaundice/liver problems | <input type="checkbox"/> Numbness or weakness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Passing out |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other stomach/colon problems | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Pain in ears, sinuses, throat, or teeth | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Other neurologic concerns |
| <input type="checkbox"/> Prolonged hoarseness | <input type="checkbox"/> Gas or bloating | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Frequent bloody nose | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Coordination problems |
| <input type="checkbox"/> Mouth sores | | |
| <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Pain/difficulty with urination | <input type="checkbox"/> Depression, tearfulness |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Anxiety/panicky feelings |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Other emotional problems |
| | <input type="checkbox"/> Leaking urine | <input type="checkbox"/> Sleep/concentration problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Other kidney/urinary problems | <input type="checkbox"/> Any history of mental problems |
| <input type="checkbox"/> Chest pain/pressure | | <input type="checkbox"/> Disordered Eating |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes/blood sugar problems | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid problems/goiter | <input type="checkbox"/> Previous blood transfusion |
| <input type="checkbox"/> Irregular/fast heartbeat | <input type="checkbox"/> Excess thirst/hunger/urination | <input type="checkbox"/> Abnormal bleeding/bruising |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Infertility | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Swelling in legs | <input type="checkbox"/> Excess heat/cold intolerance | <input type="checkbox"/> Anemia/other blood problems |
| <input type="checkbox"/> Mitral Valve Prolapse | | <input type="checkbox"/> Blood clot in leg or lung |
| <input type="checkbox"/> Other heart problems | <input type="checkbox"/> Back or neck pain | |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Joint pain or swelling | |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Morning stiffness < 1/2 hr. | |
| <input type="checkbox"/> Leg pain on walking | <input type="checkbox"/> Morning stiffness > 1/2 hr. | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Gout | |

- Immune problems or frequent infections
- Food Sensitivities:

Other:

15. Review of Systems:
(continued)

Males Only:

- Exposure to venereal disease
- Exposure to AIDS
- Discharge from the penis
- Lumps in the testicles
- Hernia in the groin
- Prostate problems
- Sexual difficulties

Females Only:

- Breast lumps
- Abnormal mammogram
- Abnormal menstrual bleeding
- Premenstrual Syndrome (PMS)
- Vaginal discharge
- Abnormal pap smear
- Abnormal pelvic pain
- Breast Implants

- Exposure to venereal disease
- Exposure to AIDS
- Sexual difficulties
- Menopausal
- Currently Pregnant
- Number of pregnancies _____
- Number of live births _____
- Number of children living _____

16. Life Habits:

	None	Small	Medium	Large
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugared products	<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"/>
Fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prayer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Family History

Please list medical problems. Include diseases such as heart disease, high blood pressure, diabetes, cancer (which type), alcoholism, mental illness, high cholesterol, stroke, kidney disease, liver disease, bleeding disorders, depression, anxiety, chronic pain, arthritis, osteoporosis, or any other significant illness.

(A) denotes alive (D) denotes deceased

Your father's father _____

Your father's mother _____

Your mother's father _____

Your mother's mother _____

Your father _____

Your mother _____

Aunts or Uncles _____

Sibling _____

Sibling _____

Child _____

Child _____