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Name: _____ Date of Birth: _____ Date: _____

Primary reason for today's visit: _____

Have you received treatment for this condition? _____ If yes, by whom? _____

What was the diagnosis?_____ How long have you had this condition?_____

Do you know what caused it? _____

What have you done to treat the problem? _____

To what extent does it interfere with your daily life? _____

Are you taking any medications? _____ If yes, please list:_____

Supplements? _____ If yes, please list:_____

Do you consider your health to be: Excellent Good Fair Poor

Do you have any chronic infectious disease? Yes No If Yes, explain: _____

Are you currently suffering from any chronic illness? Yes No If Yes, explain: _____

Please list any foods, drugs, medications or herbs that you are hypersensitive or allergic to (please include type of reaction):

_____

Please list any surgeries and date: _____

**Height**: _____ **Weight**: _____ Past Maximum Weight: _____ When? _____

Are you happy with your current weight? _____ If no, please explain: _____

**Blood Pressure**: What is your most current blood pressure reading? _____ / _____ Date: _____

**Family History:** Cancer Diabetes Heart Disease HTN Stroke Mental Illness

**For the following please circle any symptoms that you experience now and underline any symptoms that you have experienced in the past:**

**Musculoskeletal:** Neck/Shoulder Pain Muscle Spasms/Cramps Muscle Weakness Arm Pain Back Pain Leg Pain Broken Bones Joint Pain (where?) _____

**Emotional:** Mood Swings Nervousness Mental Tension Anxiety Depression

**Energy and Immunity:** Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

**Head, Eye, Ear, Nose and Throat:** Impaired Vision Glasses/Contacts Tearing/Dryness Eye Pain/Strain Glaucoma Impaired Hearing Ringing in Ears Ear Aches Frequent Sore Throats Hay Fever/Allergies Nose Bleeds Sinus Problems Headaches Head Injury Teeth Grinding TMJ Lip or Mouth Sores Gum Problems

**Respiratory:** Difficulty Breathing Frequent Common Colds Persistent Cough Pneumonia Bronchitis Emphysema Pleurisy Asthma Tuberculosis

**Endocrine:** Hyper or Hypo thyroid Diabetes Feeling Hot or Cold Night Sweats

**Cardiovascular**: Heart Disease Chest Pain Shortness of Breath Palpitations/Fluttering Heart Murmur HTN Stroke Fainting Ankle Swelling Varicose Veins

**Gastrointestinal:** Trouble Swallowing Nausea/Vomiting Heartburn Change in Appetite Change in Thirst Bloating Belching or Passing Gas Abdominal Pain Constipation Diarrhea Undigested Food Mucous or Blood in Stool Hemorrhoids Gall Bladder Disease Liver Disease Hepatitis B or C

**Neurological:** Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

**Female Reproductive/Breasts:** Irregular Cycles Breast Lumps/Tenderness Heavy Flow Bleeding Between Cycle Vaginal Discharge Clotting Painful Menses PMS Menopausal Symptoms Difficulty Conceiving STD Painful Intercourse Sexual Difficulties

Last menstrual period: _____

**Male Reproductive:** Sexual Difficulties Prostate Problems Testicular Pain/Swelling

**Other:** Anemia Cancer Rashes Eczema/Hive Cold Hands/Feet Headaches

**Lifestyle:**

Please indicate typical food intake:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you feel that you have healthy eating habits?

Consumption of liquids (ie. water, soda):

Nicotine/Alcohol/Caffeine use:

Daily Exercise:

Sleep Habits:

Education:

Occupation: Employer: Hours/Week:

Do you enjoy work? Why/Why not?

Have you experienced any major traumas? Y N Explain:

Television Habits:

Interests and Hobbies: