INITIAL HEALTH HISTORY Today's Date ____ / ____ / ____

We value your time and your knowledge of your condition. We also recognize that one part of the body can affect function in another part. So, this important information will help the doctor help you most quickly and completely.

Title: Mr /Ms /Miss /Mrs Patient Name:_____ Birthdate_____ Gender: Male/Female
Address:_____ City:_____ State:_____ Zip: _____
Hm Phone:_____ Cell:_____Email _____
Wk Phone:_____Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

List your **conditions or symptoms** **When it began** and **Frequency** **average Severity**
List Main conditions first, and others you will or may want help with at some point. (0=None, 10= worst imaginable)

1. _____ Started: _____ 1 2 3 4 _ All x Day/Wk/Mnth **0 1 2 3 4 5 6 7 8 9 10**
2. _____ Started: _____ 1 2 3 4 _ All x Day/Wk/Mnth **0 1 2 3 4 5 6 7 8 9 10**
3. _____ Started: _____ 1 2 3 4 _ All x Day/Wk/Mnth **0 1 2 3 4 5 6 7 8 9 10**
4. _____ Started: _____ 1 2 3 4 _ All x Day/Wk/Mnth **0 1 2 3 4 5 6 7 8 9 10**
5. _____ Started: _____ 1 2 3 4 _ All x Day/Wk/Mnth **0 1 2 3 4 5 6 7 8 9 10**
6. _____ Started: _____ 1 2 3 4 _ All x Day/Wk/Mnth **0 1 2 3 4 5 6 7 8 9 10**

Is this? Work Related Auto Related Neither

Time of the day do you feel **most energy or least symptoms**
☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Time of the day do you feel **least energy or most symptoms**
☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Date of last physical exam _____ Practitioner name _____MD / DC / DO Location_____

Laboratory procedures (e.g., stool analysis, blood, urine, stool) and **Imaging procedures** (e.g. x-ray, MRI, CT) performed :

_____

Results _____

What **types of therapy have you tried** for this problem(s)?: ☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs

☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ Physical Therapy ☐ Counseling ☐ conventional drugs

☐ other _____

Results _____

_____

List other current health problems for which you are being treated: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? YES / NO

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Are you recovering from a **cold or flu**? YES / NO Are you **pregnant**? YES / NO

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 wear? ☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/ prosthetics/ implants, describe: _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right **Height** _____ Your **weight today** is _____lbs

Is your sleep disturbed at the same time each night? YES / NO If yes, what time? _____ am/pm Reason? _____

Stroke Risk: **1)** Do you bruise Easily? YES / NO; **2)** Do you have a History of Migraine headaches YES / NO;

3) Are you feeling a RECENT, Sudden(taking 1- 30 minutes), *severe*, unexplained neck or head pain? YES / NO;

4) Are you noticing MORE difficulty, Walking, Feeling, Seeing, Swallowing or have new Dizziness or Vertigo that IS NOT directly related to the **Discomfort**? YES / NO

-- **Answering Yes to question 3 plus any other is reason to seriously consider emergency room care.**

Do you experience any of these general symptoms MOST DAYS? ☐ None

☐ Constipation	☐ Nausea	☐ Low grade fever	☐ Insomnia
☐ Diarrhea	☐ can't control bowel movements	☐ Disinterest in eating	☐ Really bad fatigue
☐ Vomiting	☐ can't control Urination	☐ Bleeding	☐ Panic attacks
☐ Headaches		☐ Discharge	☐ Shortness of breath
☐ Dizziness / Vertigo	☐ Chronic pain/inflammation	☐ Itching/rash	☐ Depression

Medical History (of yourself)

Past Present

- Carpal tunnel syndrome
- Dental problems
- Depression
- Diabetes
- Drug addiction
- Alcoholism
- Eating disorder
- Learning disabilities
- Mental illness
- Mental retardation
- Epilepsy
- Alzheimer's disease
- Migraine headaches
- Neurological problems Ex.(Parkinson's, paralysis)
- Eyes, ears, nose, throat problems
- Glaucoma
- Environmental sensitivities
- Chronic fatigue syndrome
- Fibromyalgia
- Autoimmune disease
- Arthritis
- Osteoporosis
- Gout
- Cancer
- Infection, chronic
- Food intolerance
- Gastroesophageal reflux (GERD)
- Inflammatory bowel disease
- Irritable bowel syndrome
- Ulcer
- Diverticular disease
- Colitis
- Kidney or bladder disease
- Liver disease
- Gallbladder disease (stones)
- Sinus problems
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Asthma
- Allergies/hay fever
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Urinary tract infection
- Cholesterol, elevated
- Heart disease
- Stroke
- Blood pressure problems
- Thyroid trouble
- Obesity
- Circulatory problems
- Varicose veins
- Genetic disorder_____

Other _____

O None of the above

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer
- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Erectile Dysfunction (<50yo=50%↑HrtA)
- Other _____

O None of the above

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____

_____

O None of the above

- Menstrual cycle Not Started yet
- Any recent changes in normal menstrual flow (e.g., heavier, large clots,scanty) _____

Age of first period _____

Date of last gynecological exam ____

Mammogram □ + □ —

PAP □ + □ --

Form of birth control □ N/A _____

# of children _____

# of pregnancies _____

- C-section _____
- Surgical menopause
- Natural Menopause

Date of last menstrual cycle_____

Days of bleeding _____ days

Days between cycles: ____days

Family Health History

(write # of Parents, Sibling, relatives)

- ___ Rheumatoid Arthritis
- ___ Asthma
- ___ Alcoholism
- ___ Alzheimer's disease
- ___ Cancer
- ___ Depression
- ___ Drug addiction
- ___ Eating disorder
- ___ Genetic disorder
- ___ Glaucoma
- ___ Heart disease
- ___ Obesity
- ___ Diabetes
- ___ Infertility
- ___ Learning disabilities
- ___ Mental illness
- ___ Mental retardation
- ___ Migraine headaches
- ___ Neurological disorders (Parkinson's, paralysis, etc.)
- ___ Osteoporosis
- ___ Stroke
- ___ Suicide

Other _____

_____

O None of the above

Intake Habits (you may mark several)

- Water: ____ #glasses / day / wk
- Juices: ____ #glasses / day / wk
- Alcohol:
  - Wine: ____ #glasses / day / wk
  - Liquor: ____ #glasses / day / wk
  - Beer: ____ #glasses / day / wk
- Caffeine:
  - Coffee: ____ #6 oz cups/d
  - Tea: ____ #6 oz cups/d
  - Soda w/caffeine: ____ #cans/day
  - Other sources _____

Other Drink : ___ #glasses / day / wk

_____

- Tobacco:
  - Cigarettes: #/day _____
  - Cigars: #/day _____
  - Other: #/day _____

Food Frequency(average)

____ # Fast Food Meals / avg. week

____ % Fruit &Veggies eaten Raw

(Servings(=palm-full size) **per avg day:**

Fruits (citrus, melons, etc.) ……____

Dark green or deep yellow/orange vegetables ……..….____

Grains (unprocessed)……..….____

Processed grains(bread, cereal, etc).____

Beans, peas, legumes ……...____

Dairy ……...____

Eggs(how many) ……____

Meat, poultry, fish ……..…..____

Eating Habits (you may mark several)

- Vegetarian □ Vegan
- Salt □ Fat restriction
- Starch/carbohydrate restriction
- _____ Diet
- Skip breakfast
- 1 □ 2 □ 3 meal(s) per day
- Graze (small frequent meals)
- Generally eat on the run

Specfic Food Restrictions

- dairy □ wheat □ eggs
- soy □ corn □ all gluten

Other _____

Exercise

- I do not work out
- I attend a gym
- I have home exer equipment / stab ball
- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Cycle
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Yoga
- Other _____

Current Supplements

O I do not take supplements

- Multivitamin/mineral

If yes, brand _____

- Vitamin C / E / A
- CoQ10
- Antioxidants (e.g., lutein, etc.)
- Omega fatty acids (EPA/DHA, etc.)
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium, Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- Herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Herbs - teas

Other _____

Sleeping Habits

___ hours per night, usually

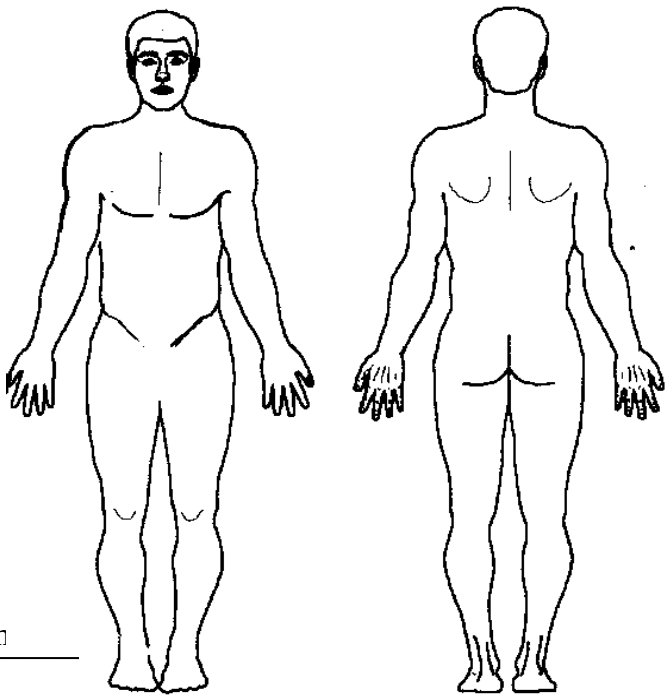
I would like ASSISTANCE to:

MUCH A Little

- Be free of pain
- Be free of numbness
- Have more energy
- Be thinner / lower body fat
- Have healthier nails / hair
- Think more clearly / focused
- Not be dependent on medications, incl. aspirin,ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives / stool softener
- Reduce Digestive Problems
- Sleep better
- Get less colds and flus
- Get rid of allergies
- Have agreeable body odor
- Detoxification / Cleansing
- ADHD / Autism / Dyslexia
- Improve Sports Performance
- Reduce Fatigue
- Slow Arthritis Degeneration
- Have Pregnancy / Delivery comfort
- Reduce risk of inherited disease (e.g., cancer,heart disease, etc.)
- Other _____

MUCH A Little

Please mark (with a number) the sites of any **surgeries, and** significant **accidents,** or **injuries – do your best**.
Then describe it in the numbered spaces below.
You may use a number in multiple sites if the single injury involved more than one location.



	When	**What happened and/or What for?**
Example:	*Jan '04*	*left knee cartilage surgery after football injury .*
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

Or, ☐ I have had no surgeries, or only (circle) Tonsils, Wisdom

☐ I am taking no medications

Note: If you have a list , you may leave this blank and give us the list to copy.

Medications	What for?	When Started?	Still Taking it?	How often?
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly

Family Physician name _____
(If you approve, we'll send them a summary of our findings about you.) Sign Here if you approve: _____

How did you decide to come to our office (mark **ALL that affected** in your decision)

☐ Friend or Relative _____ (If we know who, we'll send them a "Thank You.")

☐ Doctor or other practitioner _____

☐ Insurance ☐ Our Website ☐ PhBook (name) _____ ☐ Other _____

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN SIGNATURE _____ DATE _____