

Date: _____

Health History

Name _____

Address _____

Daytime Phone _____ Evening Phone _____

Cell Phone _____ E-mail _____

Occupation _____ DOB _____ Age _____

Referred by _____

Family Physician _____ Phone Number _____

Specialists _____

Height _____ Weight _____ Sex _____ Blood Type _____

LIST MEDICATIONS (include diet pills, painkillers, etc.):

<u>Name</u>	<u>Purpose</u>	<u>Dose/How Often</u>
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VITAMIN AND MINERAL SUPPLEMENTATION (Please bring to intake):

<u>Type</u>	<u>Manufacturer</u>	<u>No. of Mg. or IU/day</u>
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OTHER NUTRIENT SUPPLEMENTATION (i.e. amino acids, digestive enzymes, essential fatty acids, herbs, etc.):

<u>Type</u>	<u>Manufacturer</u>	<u>No. of Mg or IU/day</u>
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PAST MEDICAL HISTORY (please include dates):

Childhood Illnesses: _____

Surgeries: _____

Other illnesses (describe): _____

Accidents or Significant Traumas (describe): _____

Birth History (prolonged labor, forceps delivery, etc): _____

FAMILY MEDICAL HISTORY:

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES. ARE THEY IMPROVING OR WORSENING?

DAILY EATING HABITS (list typical food/beverage and time):

Breakfast:

Lunch:

Dinner:

Snacks:

ALCOHOL USE (number of drinks daily/weekly):

SUGAR/SALT/CHOCOLATE (crave or eat):

CAFFEINE USE (amt. per day/week include colas, Excedrin, Aspirin, Anacin, Midol, Cope, No Dose, etc., these contain caffeine):

INDICATE STRESS DIFFICULT TO MANAGE (check-off):

Environmental Financial Family
 Work School Relationship Personal

EFFECTS OF STRESS (List habits resulting from stress indicators, i.e. drinking, smoking, eating, not eating, insomnia, medications, over-the-counter and other drugs, tension, anger, etc.):

WHAT DO YOU DO FOR FUN AND ADVENTURE? HOW OFTEN?

WHAT DO YOU DO JUST FOR YOURSELF? HOW OFTEN?

DO YOU MEDITATE OR REFLECT SPIRITUALLY?

LIST PHYSICAL EXERCISE OR BODY

<u>Activity</u>	<u>How Often</u>
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LIST ANY CHIEF COMPLAINTS AND DISCOMFORTS, AND PROGRAM GOALS.
HAS YOUR PHYSICIAN GIVEN YOU A DIAGNOSIS?

General Symptoms: (check all that apply)

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Heavy appetite	<input type="checkbox"/> Cold back
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet	<input type="checkbox"/> Heavy sleep
<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Cravings

___ Strong thirst (hot/cold) ___ Tremors ___ Peculiar tastes/smells (explain):
 ___ Bleed or bruise easily (describe where):

Cardiovascular

___ High Blood Pressure ___ Low Blood Pressure ___ Irregular heartbeat
 ___ Dizziness ___ Fainting ___ Cold hands/feet
 ___ Blood clots ___ Phlebitis ___ Swelling hands/feet
 ___ Difficulty breathing ___ Other (explain)

Respiratory

___ Cough ___ Coughing blood ___ Asthma
 ___ Bronchitis ___ Pneumonia ___ Tight chest
 ___ Difficulty in breathing when lying down ___ Production of phlegm (what color?)
 ___ Other (explain)

Gastrointestinal

___ Nausea ___ Vomiting ___ Diarrhea
 ___ Food sits in stomach ___ Belching & gas ___ Bad breath
 ___ Rectal pressure ___ Black stools ___ Hemorrhoids
 ___ Constipation ___ Bloody stools ___ Sensitive abdomen
 ___ Pain or cramps ___ Laxative use ___ Problems digesting fats

Bowel Movement: Frequency _____ Color _____
 Odor _____ Texture/form _____

Genito-Urinary

___ Pain on urination ___ Frequent urination ___ Blood in urine
 ___ Urgency to urinate ___ Unable to hold urine ___ Kidney stones
 ___ Venereal disease ___ Impotency ___ Other G/U problems
 ___ Wake up to urinate How often _____/night;time(s): _____

Musculoskeletal

___ Neck pain ___ Muscle pains ___ Back pains (where)
 ___ Joint pains (where): ___ Other joint or bone problems (explain):

Neuropsychological

___ Seizures ___ Areas of numbness ___ Poor memory
 ___ Concussion ___ Depression ___ Easily stressed
 ___ Bad temper ___ Anxiety ___ Other (explain)
 ___ Treated for emotional problems ___ Considered/attempted suicide

Pregnancy and Gynecology (if applicable)

Number of pregnancies _____ Number of birth _____ Ages now _____
 Premature births _____ Miscarriages _____ Age at first menses _____
 Period (days) _____ Duration _____ Irregular periods _____
 Flow (describe): _____
 Last menses _____ Menopause _____ Last PAP _____
 Birth control (type) _____ How long _____
 ___ Clots ___ Breast lumps ___ Vaginal sores ___ Vaginal discharge
 ___ Fibroids (breast or uterus) ___ Heavy bleeding ___ Food cravings (list)
 Changes in body/mood prior to menstruation (describe):

Prostate History (if applicable)

___ Enlarged prostate (hyperplasia) ___ Prostatitis ___ Abscesses
 ___ Benign ___ Calculi ___ Carcinoma
 ___ Incontinence ___ Bladder outlet obstruction
 Has serum PSA been tested? ___ Yes ___ No

Results: