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Name____ Date_____________________

Address____

City______________________________ State___________ Zip code_____________________

Home Number__________________________ Cell____________________________________

Email____

Date of Birth_______________________ Age_________ Gender_________________________

Married_____ Separated____ Divorced______ Widowed_____ Single______ Partnership________

Live with: Spouse______ Partner_____ Parents_____ Children_____ Friends_____ Alone________

Occupation________________________________ Hours per week_______ Retired__________

Work Address____

How did you hear about our clinic? ____

Primary Care Physician_______________________________ Phone_______________________

Insurance Carrier____

Emergency Contact____

Relationship_____________________________ Phone_________________________________

What are your most important health concerns? List as many as you can in order of importance:

1.____

2.____

3.____

4.____

Childhood Illnesses

(PLEASE MARK ONLY YES ANSWERS)

Scarlett Fever	______	Diphtheria	_____	Rheumatic Fever	______
Mumps	______	Measles	_____	German Measles	______

What hospitalizations or surgeries have you had?

____________________________ year: _________ ____________________________year: ________________

____________________________ year: _________ ____________________________ year: ________________

X-rays, CAT scans or other studies you have had:

____

Electrocardiogram? ____

Immunizations

Polio	______	Diphtheria	______	Tetanus Shot	______
Pertussis	______	Measles	______	Chicken Pox	______
Hepatitis	______	Mumps	______	Rubella	______

Allergies

Are you hypersensitive or allergic to?

Any drugs? ____

Any foods? ____

Any environmental or chemical sensitivities? ____________________________________

Current Medications

Laxatives	Y___N___P___	Pain Relievers	Y___N___P___	Antacids	Y___N___P___
Cortisone	Y___N___P___	Antibiotics	Y___N___P___	Tranquilizers	Y___N___P___
Diet Pills	Y___N___P___	Thyroid Medication	Y___N___P___	Sleeping Pills	Y___N___P___

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking.

1.____ 4. ____

2.____ 5. ____

3.____ 6. ____

General

Height: _____________ Weight: _____________ lbs. Weight 1 year ago _________ lbs.

Maximum Weight: _____________ When: _____________

When during the day is your energy the best?_____________worst? __________________

Typical Food Intake

Breakfast____

Lunch____

Dinner____

Snacks____

To Drink____

Family History

Do you have a family history of any of the following? **(PLEASE MARK ONLY YES ANSWERS)**

Cancer___	Diabetes _____	Heart Disease____	High Blood Pressure ___	Kidney Disease _____
Hives ___	Arthritis _____	Glaucoma _____	Tuberculosis ___	Stroke _____
Anemia___	Asthma _____	Epilepsy _____	Hay Fever ___	Mental Illness _____

Any other relevant family history? ____

____

Y = a condition you **have now** **N** = a condition you **never had** **P** = a condition you have **had in the past**

Habits

Main Interests and hobbies?____

Do you exercise?_______ If yes, what kind?____

Average 6-8 hours of sleep	Y___N___P___	Enjoy your work	Y___N___P___
Awaken Rested	Y___N___P___	Take Vacations	Y___N___P___
Supportive Relationship	Y___N___P___	Watch TV	Y___N___P___
History of abuse	Y___N___P___	Hours_______________	
Any major traumas	Y___N___P___	Read	Y___N___P___
Use recreational drugs	Y___N___P___	Hours_______________	
Treated for drug dependency	Y___N___P___	Eat 3 meals a day	Y___N___P___
Drink alcoholic beverages	Y___N___P___	Diet often	Y___N___P___
Treated for alcoholism	Y___N___P___	Eat out often	Y___N___P___
Use tobacco	Y___N___P___	Drink Coffee	Y___N___P___
Smoked Previously	Y___N___P___	Black/Green Tea	Y___N___P___
How many years?________________________		Drink Cola or Soda	Y___N___P___
How many packs per day?________________		Eat refined sugar	Y___N___P___
		Do you add salt	Y___N___P___

Do you have a religious or spiritual practice? Y___N___P___

Review of the Systems

Mental/Emotional

Treated for emotional problems	Y___ N___P___	Depression	Y___ N___P___
Mood Swings	Y___ N___P___	Anxiety/nervousness	Y___ N___P___
Considered/attempted suicide	Y___ N___P___	Tension	Y___ N___P___
Poor concentration	Y___ N___P___	Memory problems	Y___ N___P___

Immune

Reactions to immunizations	Y___N___P___	Reactions to vaccinations	Y___N___P___
Chronic Fatigue Syndrome	Y___N___P___	Slow wound healing	Y___N___P___
Chronic/Recurring Infections	Y___N___P___	Chronic swollen glands	Y___N___P___
Autoimmune Disease	Y___N___P___		

Endocrine

Hypothyroid	Y___N___P___	Heat or cold intolerance	Y___N___P___
Hypoglycemia	Y___N___P___	Diabetes	Y___N___P___
Excessive Thirst	Y___N___P___	Excessive Hunger	Y___N___P___
Fatigue	Y___N___P___	Seasonal Depression	Y___N___P___

Neurologic

Seizures	Y___N___P___	Paralysis	Y___N___P___
Muscle Weakness	Y___N___P___	Numbness/Tingling	Y___N___P___
Loss of memory	Y___N___P___	Easily Stressed	Y___N___P___

Skin

Rashes	Y___N___P___	Eczema, Hives	Y___N___P___
Acne, Boils	Y___N___P___	Itching	Y___N___P___
Color Change	Y___N___P___	Perpetual hair loss	Y___N___P___
Lumps	Y___N___P___	Night Sweats	Y___N___P___

Head

Headaches	Y___N___P___	Migraines	Y___N___P___
Head Injury	Y___N___P___	Jaw/TMJ	Y___N___P___

Eyes

Spots in Eyes	Y___N___P___	Cataracts	Y___N___P___
Impaired Vision	Y___N___P___	Glasses/Contacts	Y___N___P___
Blurriness	Y___N___P___	Eye pain/strain	Y___N___P___
Color Blindness	Y___N___P___	Tearing/Dryness	Y___N___P___
Double Vision	Y___N___P___	Glaucoma	Y___N___P___

Ears

Impaired Hearing	Y___N___P___	Ringing	Y___N___P___
Earaches	Y___N___P___	Dizziness	Y___N___P___

Nose and Sinuses

Frequent Colds	Y___N___P___	Nose Bleeds	Y___N___P___
Stuffiness	Y___N___P___	Hay Fever	Y___N___P___
Sinus Problems	Y___N___P___	Loss of Smell	Y___N___P___

Mouth and Throat

Frequent Sore Throat	Y___N___P___	Copious Saliva	Y___N___P___
Teeth Grinding	Y___N___P___	Sore Tongue/Lips	Y___N___P___
Gum Problems	Y___N___P___	Hoarseness	Y___N___P___
Silver Fillings	Y___N___P___	Jaw Clicks	Y___N___P___
Root Canal	Y___N___P___		

Neck

Lumps	Y___N___P___	Swollen Glands	Y___N___P___
Goiter	Y___N___P___	Pain or Stiffness	Y___N___P___

Respiratory

Condition	Response	Condition	Response
Cough	Y___N___P___	Sputum	Y___N___P___
Spitting Blood	Y___N___P___	Wheezing	Y___N___P___
Asthma	Y___N___P___	Bronchitis	Y___N___P___
Pneumonia	Y___N___P___	Pleurisy	Y___N___P___
Emphysema	Y___N___P___	Tuberculosis	Y___N___P___
Difficulty breathing	Y___N___P___	Shortness of breath	Y___N___P___
Shortness of breath at night	Y___N___P___	Shortness of breath lying down	Y___N___P___

Cardiovascular

Condition	Response	Condition	Response
Heart Disease	Y___N___P___	Angina	Y___N___P___
High/Low Blood Pressure	Y___N___P___	Murmurs	Y___N___P___
Blood Clots	Y___N___P___	Fainting	Y___N___P___
Phlebitis	Y___N___P___	Palpitations/Flutters	Y___N___P___
Rheumatic Fever	Y___N___P___	Chest Pain	Y___N___P___
Swelling in ankles	Y___N___P___		

Gastrointestinal

Condition	Response	Condition	Response
Trouble swallowing	Y___N___P___	Heartburn	Y___N___P___
Change in thirst	Y___N___P___	Abdominal pain/cramps	Y___N___P___
Change in appetite	Y___N___P___	Belching/passing gas	Y___N___P___
Nausea/vomiting	Y___N___P___	Constipation	Y___N___P___
Ulcer	Y___N___P___	Diarrhea	Y___N___P___
Jaundice (Yellow Skin)	Y___N___P___	Bowel Movements- How often	______________________
Gall Bladder Disease	Y___N___P___		
Liver Disease	Y___N___P___	Black Stools	Y___N___P___
Hemorrhoids	Y___N___P___	Blood in stool	Y___N___P___
Candida/Thrush	Y___N___P___		

Urinary

Condition	Response	Condition	Response
Pain on urination	Y___N___P___	Increased Frequency	Y___N___P___
Frequency at night	Y___N___P___	Inability to hold urine	Y___N___P___
Frequent infections	Y___N___P___	Kidney Stones	Y___N___P___

Musculoskeletal

Condition	Response	Condition	Response
Joint Pain	Y___N___P___	Arthritis	Y___N___P___
Broken Bones	Y___N___P___	Weakness	Y___N___P___
Muscle Spasms/Cramps	Y___N___P___	Sciatica	Y___N___P___

Blood/Peripheral Vascular

Condition	Response	Condition	Response
Easy bleeding	Y___N___P___	Anemia	Y___N___P___
Deep leg pain	Y___N___P___	Cold hands/feet	Y___N___P___

Male Reproduction

Hernias Y___N___P___
Testicular Pain Y___N___P___
Venereal disease Y___N___P___
Are you sexually active? Y___N___P___
Sexual Orientation______________________________
Impotence Y___N___P___
Herpes Y___N___P___

Testicular Mass Y___N___P___
Prostate Disease Y___N___P___
Discharge or sores Y___N___P___
Gonorrhea Y___N___P___
Chlamydia Y___N___P___
Genital Warts Y___N___P___
Syphilis Y___N___P___

Female Reproduction/Breast

Age of first menses_____________________________
Age of last menses (if menopausal)______________
Length of cycle__________________________________
Duration of menses_______________________________
Spotting between cycles Y___N___P___
Painful menses Y___N___P___
Heavy excessive flow Y___N___P___
PMS Y___N___P___
If yes, what are your symptoms?__________________
____
____
Endometriosis Y___N___P___
Ovarian Cysts Y___N___P___
Difficulty Conceiving Y___N___P___
Cervical Dysplasia Y___N___P___
Are you sexually active? Y___N___P___
Sexual Orientation______________________________
Do you do breast self-exams Y___N___P___
Have you ever had a yeast infection Y___N___P___

Date of last annual exam/PAP____________
Regular Cycles Y___N___P___
Clotting Y___N___P___
Discharge Y___N___P___
Birth Control Y___N___P___
What type?_____________________________
Number of pregnancies__________________
Number of live births___________________
Number if miscarriages _________________
Number of abortions____________________
Menopausal Symptoms Y___N___P___
Abnormal PAP Y___N___P___
Chlamydia Y___N___P___
Genital Warts Y___N___P___
Syphilis Y___N___P___
Breast Lumps Y___N___P___
Nipple Discharge Y___N___P___
Breast Pain/Tenderness Y___N___P___

Other

Have you ever been diagnosed with Lyme Disease? Y___N___P___

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.