Patient Health History:

Name: ______________________ Date of Birth: ____________ Today's Date: ____________

Occupation: ______________________ Age: ______ Height: ______ Sex: _____ Number of Children: _____

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

Are you recovering from a cold or flu? ❑ Y ❑ N Are you pregnant? ❑ Y ❑ N

Reason for office visit: Date began:

Date of last physical exam: ____________ Practitioner name and phone number: ______________________

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

Outcome: ______________________

What types of therapy have you tried for this problem(s): ❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs ❑ none ❑ other ____________

List current health problems for which you are being treated: ______________________

Current medications (prescription or over-the-counter): ______________________

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year: Operation, Illness, Injury: Outcome:

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 consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today: ____________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ❑ Y ❑ N

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents), or health and/or life threatening activities (e.g., fireman, farmer, hair stylist)? ❑ Y ❑ N ______________________

I have: ❑ Corrective lenses ❑ Dentures ❑ Hearing Aid ❑ Medical devices/prosthetics/implants, describe: ____________

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)

Strong **like** for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong **dislike** for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ prefer warmth (i.e., food, drinks, weather, etc.) ❑ prefer cold (i.e., food, drinks, weather, etc.) ❑ no preference

Is your sleep disturbed at the same time each night? ❑ Y ❑ N if yes, what time? ____________

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m.—9 a.m. ❑ 9 a.m.—11 a.m. ❑ 11 a.m.—1 p.m.
❑ 1 p.m.—3 p.m. ❑ 3 p.m.—5 p.m. ❑ 5 p.m.—7 p.m.
❑ 7 p.m.—9 p.m. ❑ 9 p.m.—11 p.m. ❑ 11 p.m.—1 a.m.
❑ 1 a.m.—3 a.m. ❑ 3 a.m.—5 a.m. ❑ 5 a.m.—7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m.—9 a.m. ❑ 9 a.m.—11 a.m. ❑ 11 a.m.—1 p.m.
❑ 1 p.m.—3 p.m. ❑ 3 p.m.—5 p.m. ❑ 5 p.m.—7 p.m.
❑ 7 p.m.—9 p.m. ❑ 9 p.m.—11 p.m. ❑ 11 p.m.—1 a.m.
❑ 1 a.m.—3 a.m. ❑ 3 a.m.—5 a.m. ❑ 5 a.m.—7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue ❑ Shortness of breath ❑ Insomnia ❑ Constipation ❑ Chronic pain/inflammation
❑ Depression ❑ Panic attacks ❑ Nausea ❑ Fecal incontinence ❑ Bleeding
❑ Disinterest in sex ❑ Headaches ❑ Vomiting ❑ Urinary incontinence ❑ Discharge
❑ Disinterest in eating ❑ Dizziness ❑ Diarrhea ❑ Low grade fever ❑ Itching/rash

MEDICAL HISTORY

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

Other ____________________

____

MEDICAL (Men only)

- ❑ Benign Prostate Hypertrophy
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ STD

Other____________________

____

MEDICAL (Women only)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ PMS
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ STD

Other ____________________

____

Age of first period ____________________

Date of last gynecological exam ____________

Mammogram ❑ + ❑ -

PAP ❑ + ❑ -

Form of birth control ____________________

# of children ____________________

# of pregnancies ____________________

- ❑ C section
- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle ____________

Length of cycle _____ days

Interval of time between cycles ________ days

Any recent changes in normal menstrual flow (e.g. heavier, large clots, scantier)

____

____

FAMILY HEALTH HISTORY (parents & siblings)

- ❑ Arthritis, rheumatoid
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucauma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkenson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other ____________________

____

HEALTH HABITS

❑ **Tobacco:**

Cigarettes: #/day ____________________

Cigars: #/day ____________________

❑ **Alcohol:**

Wine: # glasses ________ ❑ Day ❑ Week

Liquor: # glasses ________ ❑ Day ❑ Week

Beer: # glasses ________ ❑ Day ❑ Week

❑ **Caffeine:**

Coffee: # 6oz cups ______ ❑ Day ❑ Week

Tea: # 6oz cups ________ ❑ Day ❑ Week

Soda w/caf.: # cans ______ ❑ Day ❑ Week

Other sources ____________________

❑ **Water:** # 8oz glasses/day ____________

EXERCISE

- ❑ 5 — 7 days per week
- ❑ 3 — 4 days per week
- ❑ 1 — 2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30 — 45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Other ____________________

NUTRITION & DIET

- ❑ Mixed food diet (animal & vegetable)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone diet
- ❑ Atkins diet
- ❑ South Beach diet

Other diet ____________________

- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs ❑ soy

❑ corn ❑ all gluten

Other ____________________

FOOD INTAKE FREQUENCY

Servings per day:

Fruits (citrus, melons, etc.) ____________

Dark green or deep yellow/orange vegetables ____________

Grains (unprocessed) ____________

Beans, peas, legumes ____________

Dairy, eggs ____________

Meat, poultry, fish ____________

EATING HABITS

- ❑ Skip breakfast
- ❑ Two meals per day
- ❑ One meal per day
- ❑ Graze (small, frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

CURRENT SUPPLEMENTS

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ Omega3 fatty acids/fish oil
- ❑ Evening Primrose/GLA
- ❑ Calcium, source ____________________
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe ____________________
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants
- ❑ Herbs – teas
- ❑ Herbs – extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g.. bee pollen, phytonutrient blends)
- ❑ Liquid meals (e.g.. Ensure)

Other ____________________

____

WOULD YOU LIKE TO:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g. cancer, heart disease, etc.)