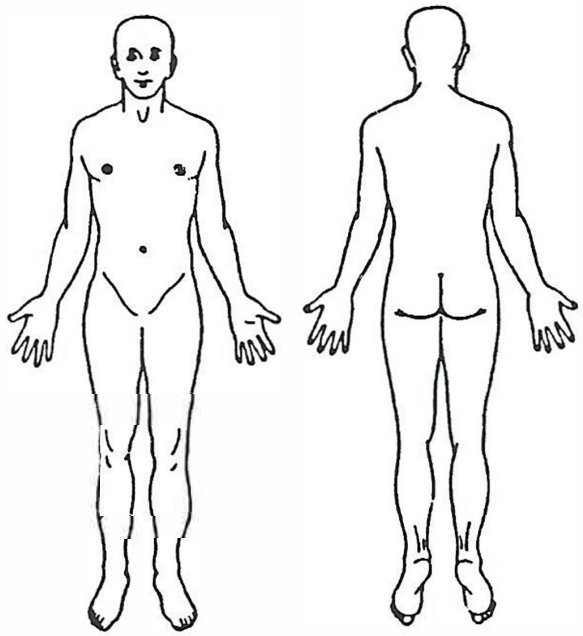
PATIENT HISTORY

Name: _____ Phone: Home _____ Email _____
Address: *(street)* _____ Age _____ Ht.: _____ Wt: _____ Sex: _____
(city) _____ Birth Date: _____ Marital status: _____ No. of children: _____
(state) _____ *(zip)* _____ Occupation: _____ [redacted] _____
Employer's Name and Address: Not required at this time
Primary Physician: _____ Referred by: _____
In emergency, contact: _____ Emergency phone number: _____
Their address: _____ Relationship: _____
Insurance Company's Name and Address: Not required at this time
Check: ☐ Individual Policy ☐ Group Policy Insurance Policy Number: Not required at ths time

PURPOSE FOR COMING: _____

MAJOR COMPLAINT only: _____

If you are in pain, please mark the exact location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity which brings on or aggravates the pain. (i.e. abdominal sharp pain, every 30 seconds, for the last two hours when standing or sitting.)



How did this condition develop? (What caused it? How did it start?) _____

When was the first time you were aware of this condition? _____

Have you ever had this condition or similar condition before? If yes, please explain: _____

Have you ever received any treatment for this condition?
☐ Yes ☐ No If yes, where? _____
When? _____
By whom? _____
What was the diagnosis? _____
What were the results of treatment? _____

Has the condition been getting ☐ better ☐ worse or ☐ staying the same?

Are you experiencing physical, mental, or emotional stress at ☐ home or ☐ at work ☐ other _____

How has this condition affected the following:
Your home life: _____
Your work experience: _____
Your social life: _____
Your ability to exercise: _____
Rest and sleep: _____
Other: _____

State injuries you have had, related or otherwise, to your condition: _____

☐ Broken bones ☐ Concussion or Head Injury ☐ Dislocations ☐ Sprains ☐ Loss of Consciousness

Name:_____ Date: _____

CHECK CURRENT CONDITIONS. CIRCLE FORMER CONDITIONS. STATE duration, frequency, intensity and pain in the space beside current symptoms.

GENERAL SYMPTOMS
- ☑ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Loss of weight
- ☐ Forgetfulness
- ☐ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, or feet
- ☐ Confusion
- ☐ Paralysis

EYES, EARS, NOSE AND THROAT
- ☐ Failing vision
- ☐ Near sightedness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cross eyed
- ☐ Eye inflamation
- ☐ Glaucoma
- ☐ Deafness
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Hay fever
- ☐ Allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Difficult swallowing
- ☐ Loss of taste
- ☐ Change in tastes
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Tonsilitis
- ☐ Asthma
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Enlarged glands

SKIN
- ☐ Skin eruptions
- ☐ Clammy skin
- ☐ Dryness
- ☐ Bruises easily
- ☐ Boils
- ☐ Rashes
- ☐ Sensitive skin
- ☐ Hives or allergy

RESPIRATORY
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Wheezing

CARDIO-VASCULAR
- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ Irregular beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Varicose veins

MUSCLE AND JOINT
- ☐ Stiff neck
- ☐ Pain between shoulders
- ☐ Backache
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Swollen joints
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Arthritis
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

GENITOURINARY
- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostrate trouble
- ☐ Bladder trouble
- ☐ Foul smelling urine
- ☐ Discolored urine

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Gas
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Blood in stool
- ☐ Colon trouble
- ☐ Hemmorrhoids (Piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble

FEMALE
- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Congested breast
- ☐ Breast pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding
- ☐ Reduced sexual energy
- ☐ Pregnancy
- ☐ Pregnancy complications

MALE
- ☐ Pain associated with genitals
- ☐ Reduced sexual energies
- ☐ Premature ejaculation
- ☐ Seminal emission
- ☐ Impotence
- ☐ Discharges

Name: _____ **Date** _____

LAST PHYSICAL: DATE _____ DR. _____ RESULTS: _____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy	Moderate	Light	None	
☐	☐	☐	☐	Alcohol:
☐	☐	☐	☐	Coffee:
☐	☐	☐	☐	Tea:
☐	☐	☐	☐	Tobacco:
☐	☐	☐	☐	Exercise:
☐	☐	☐	☐	Sleep:
☐	☐	☐	☐	Appetite:
☐	☐	☐	☐	Energy:
☐	☐	☐	☐	Medication:
☐	☐	☐	☐	Vitamins:
☐	☐	☐	☐	Diet:
☐	☐	☐	☐	Teeth problems:
☐	☐	☐	☐	Drugs:
☐	☐	☐	☐	Salt:
☐	☐	☐	☐	Other:
☐	☐	☐	☐	Stress: _____ (Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when. _____

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs) _____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.) _____

Name: _____ Date: _____

PAST MEDICAL HISTORY

Birth: Anything significant about your birth?

Vaccination history: Any reaction that you remember?

Childhood illnesses: Any surgery or accidents? List in chronological order and indicate length of illness or injury.

Age 0-6:

Age 7-12:

Age 13-20:

Age 21-30:

Age 31-40:

Age 41 to present:

Family health history: