

PERSONAL INFORMATION

Name _____ Date _____

Address _____ City _____ Postal Code _____

Home Phone Number _____ Work _____ Mobile _____

Please put a star beside your preferred contact number May we leave messages Y N

Email Address _____ Would you like to join our free health newsletter Y N

Date of Birth: ____ / ____ / ____
Month Day Year

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

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

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Who were you referred by? _____

How did you hear about our clinic? _____

OTHER HEALTH CARE PRACTITIONERS

EMERGENCY CONTACT

Name _____ Relationship _____ Phone Number _____

REASON(S) FOR OFFICE VISIT

What types of therapies have you tried for these problem(s) or to improve your health overall:

- diet modification
 fasting
 vitamins/minerals
 herbs
 homeopathy
 chiropractic
 acupuncture
 conventional drugs
 other _____

Do you experience any of these general symptoms EVERY DAY?

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Nausea | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Disinterest in sex | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Itching/rash |
| <input type="checkbox"/> Excessive belching | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Bloating | | |

Number of bowel movements per day _____

Approximate Number of antibiotics in last 5 years _____

Any negative/allergic reactions to medications (prescription, over the counter) Y N

If so, what? _____

Current medications (prescription or overthecounter): _____

Current Supplements (including brands and dosages...if possible bring your current supplements to your initial appt): _____

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

Year	Surgery, Illness, Injury	Outcome

PREVIOUS HEALTH HISTORY

Were you Breastfed? Y N
 If yes, approximately how long? _____

Are you vaccinated? Y N

Please circle all of the following childhood conditions that you experienced:

Allergies | Asthma | Eczema | Frequent Colds | Frequent Ear Infections | Strep Throat | Diaper Rash

CURRENT HEALTH STATE

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

Circle the major cause (s) of your stress: Money | Marriage | Family | Work | Health

Do you consider yourself: Underweight Overweight Just Right

Your weight today _____lbs.

Have you had an unintentional weight loss/gain of 10 pounds+ 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, etc.)? Y N

Do you have silver fillings? Y N

Do you have a root canal? Y N

What are your current health goals: _____

MEDICAL HISTORY

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

MEDICAL (MEN)

- Benign prostatic hyperplasia
- Infertility
- Other
- Prostate cancer
- Sexually transmitted disease
- Decreased sex drive

MEDICAL (WOMEN)

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

- Surgical menopause Menopause
- Other

Date of last GYN exam: _____

Date of last Mammogram: _____

Date of last PAP test: _____

Form of birth control: _____ # of children: _____ # of pregnancies: _____

Age of first period: _____ 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, scanty): _____

FAMILY HEALTH HISTORY (PARENTS AND SIBLINGS)

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Other | |

HEALTH HABITS

Tobacco

Cigarettes: #/day _____

Cigars: #/day _____

Alcohol

Wine: #glasses/day or wk _____

Liquor: #ounces/day or wk _____

Beer: #glasses/day or wk _____

Caffeine

Coffee: #6 oz cups/day _____

Tea: #6 oz cups/day _____

Soda w/caffeine: #cans/day _____

Other sources _____

Water

#glasses/day _____

EXERCISE

- | | | |
|---|---|---|
| <input type="checkbox"/> 5 to 7 days per week | <input type="checkbox"/> 3 to 4 days per week | <input type="checkbox"/> 1 to 2 days per week |
| <input type="checkbox"/> 45 mins or more duration per workout | <input type="checkbox"/> 30 to 45 mins duration per workout | <input type="checkbox"/> Less than 30 mins duration per workout |
| <input type="checkbox"/> Walk? | <input type="checkbox"/> Run, jog, other aerobic? | <input type="checkbox"/> Weight lifting? |
| # of days/wk: _____ | # of days/wk: _____ | # of days/wk: _____ |
| <input type="checkbox"/> Stretch? | <input type="checkbox"/> Other: _____ | |
| # of days/wk: _____ | | |

NUTRITION & DIET

- | | | |
|---|---|--|
| <input type="checkbox"/> Mixed food diet (animal and vegetable sources) | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Starch/carbohydrate restriction |
| <input type="checkbox"/> Salt restriction | <input type="checkbox"/> Fat restriction | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> The Zone Diet | <input type="checkbox"/> Total calorie restriction: _____ | |
| <input type="checkbox"/> Specific food restrictions: | | |
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Corn | |
| <input type="checkbox"/> Wheat | <input type="checkbox"/> All gluten | |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Soy | | |

FOOD FREQUENCY

Number of servings per day

- | | |
|---|----------------------------|
| Fruits (citrus, melons, etc.) _____ | Beans, peas, legumes _____ |
| Dark green or deep yellow/orange vegetables _____ | Dairy, eggs _____ |
| Grains (unprocessed) _____ | Meat, poultry, fish _____ |

EATING HABITS

- | | | |
|---|---|---|
| <input type="checkbox"/> Eat one meal per day | <input type="checkbox"/> Eat two meals per day | <input type="checkbox"/> Eat three meals per day |
| <input type="checkbox"/> Eat constantly whether hungry or not | <input type="checkbox"/> Graze (small frequent meals) | <input type="checkbox"/> Generally eat on the run |
| <input type="checkbox"/> Skip meals | | |
| If so, which ones: | _____ | |

I WOULD LIKE TO... (CHECK ALL THAT APPLY)

→ Energy Vitality

- Feel more vital
- Be less tired after lunch
- Get less colds and flu
- Stop using laxatives and stool softeners
- Have more energy
- Sleep better
- Get rid of allergies
- Not be dependant on over-the-counter meds like aspirin, ibuprofen, antihistamines, sleeping aids etc.
- Have more endurance
- Been free of pain
- Improve sex drive

→ Body Composition

- Loose weight
- Have better muscle tone
- Burn more body fat
- Be more flexible
- Be stronger

→ Stress, Mental, Emotional

- Learn how to reduce stress
- Be less depressed
- Think more clearly and be more focused
- Feel more motivated
- Be less moody
- Improve memory
- Be less indecisive

→ Life Enrichment

- Reduce my risk of degenerative disease
- Change from a "treating illness" orientation to a creating wellness lifestyle orientation
- Slow down accelerated aging
- Maintain a healthier life longer