

**INITIAL HEALTH HISTORY** Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

We value your time and your knowledge of your condition. We also recognize that one part of the body can affect function in another part. So, this important information will help the doctor help you most quickly and completely.

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: Male/Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Hm Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email \_\_\_\_\_  
Wk Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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

Describe your **MAJOR PROBLEM**(s) or **Reason for office visit** and **WHEN Did It BEGIN?**  
\_\_\_\_\_  
Started: \_\_\_\_\_  
\_\_\_\_\_  
Started: \_\_\_\_\_

**Is this?** Work Related Auto Related Neither  
Time of the day do you feel **most energy or least symptoms** Time of the day do you feel **least energy or most symptoms**  
 Morning  Afternoon  Evening  Night  Morning  Afternoon  Evening  Night

**Other conditions or symptoms** you have for which you desire to be examined/treated **Now OR Eventually:**  
\_\_\_\_\_  
Started: \_\_\_\_\_  
\_\_\_\_\_  
Started: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name \_\_\_\_\_ MD / DC / DO Location \_\_\_\_\_

**Laboratory procedures** performed (e.g., stool analysis, blood and urine chemistries, hair analysis):  
\_\_\_\_\_  
Results \_\_\_\_\_

**Imaging procedures** performed (e.g. x-ray, MRI, CT): \_\_\_\_\_  
Results \_\_\_\_\_

What **types of therapy** have you tried for this problem(s)?  diet modification  fasting  vitamins/minerals  herbs  
 homeopathy  chiropractic  acupuncture  Physical Therapy  Counseling  conventional drugs  
 other \_\_\_\_\_

List other current health problems for which you are being treated: \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? YES / NO

**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)

Are you recovering from a **cold or flu**? YES / NO Are you **pregnant**? YES / NO  
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 wear?**  Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/ implants, describe: \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right **Height** \_\_\_\_\_ Your **weight today** is \_\_\_\_\_ lbs  
Is your sleep disturbed at the same time each night? YES / NO If yes, what time? \_\_\_\_\_ am/pm Reason? \_\_\_\_\_

**Stroke Risk:** **1)** Do you bruise Easily? YES / NO; **2)** Do you have a History of Migraine headaches YES / NO;  
**3)** Are you feeling a RECENT, Sudden(over 1- 30 minutes), severe neck or head pain? YES / NO;  
**4)** Are you noticing MORE difficulty, Walking, Feeling, Seeing, Swallowing or have new Dizziness or Vertigo  
that IS NOT directly related to the **Discomfort**? YES / NO  
-- **Answering Yes to question 3 plus any other is reason to seriously consider emergency room care.**

**Do you experience any of these general symptoms MOST DAYS?**  None

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Nausea                        | <input type="checkbox"/> Low grade fever       | <input type="checkbox"/> Insomnia           |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> can't control bowel movements | <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Really bad fatigue |
| <input type="checkbox"/> Vomiting            | <input type="checkbox"/> can't control Urination       | <input type="checkbox"/> Bleeding              | <input type="checkbox"/> Panic attacks      |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Discharge                     | <input type="checkbox"/> Shortness of breath   |   |
| <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Chronic pain/inflammation     | <input type="checkbox"/> Itching/rash          | <input type="checkbox"/> Depression         |

**Medical History (of yourself)**

Past Present

- Carpal tunnel syndrome
 Dental problems
 Depression
 Diabetes
 Drug addiction
 Alcoholism
 Eating disorder
 Learning disabilities
 Mental illness
 Mental retardation
 Epilepsy
 Alzheimer's disease
 Migraine headaches
 Neurological problems
Ex.(Parkinson's, paralysis)
 Eyes, ears, nose, throat problems
 Glaucoma
 Environmental sensitivities
 Chronic fatigue syndrome
 Fibromyalgia
 Autoimmune disease
 Arthritis
 Osteoporosis
 Gout
 Cancer
 Infection, chronic
 Food intolerance
 Gastroesophageal reflux (GERD)
 Inflammatory bowel disease
 Irritable bowel syndrome
 Ulcer
 Diverticular disease
 Colitis
 Kidney or bladder disease
 Liver disease
 Gallbladder disease (stones)
 Sinus problems
 Sexually transmitted disease
 Seasonal affective disorder
 Skin problems
 Asthma
 Allergies/hay fever
 Bronchitis
 Emphysema
 Pneumonia
 Tuberculosis
 Urinary tract infection
 Cholesterol, elevated
 Heart disease
 Stroke
 Blood pressure problems
 Thyroid trouble
 Obesity
 Circulatory problems
 Varicose veins
 Genetic disorder
Other
 None of the above

**Medical (Men)**

- Benign prostatic hyperplasia (BPH)
 Prostate cancer
 Decreased sex drive
 Infertility
 Sexually transmitted disease
 Erectile Dysfunction (<50yo=50%↑HrTA)
 Other
 None of the above

**Medical (Women)**

- Menstrual irregularities
 Endometriosis
 Infertility
 Fibrocystic breasts
 Fibroids/ovarian cysts
 Premenstrual syndrome (PMS)
 Breast cancer
 Pelvic inflammatory disease
 Vaginal infections
 Decreased sex drive
 Sexually transmitted disease
 Other
 None of the above
 Menstrual cycle Not Started yet
 Any recent changes in normal menstrual flow (e.g., heavier, large clots,scanty)
Age of first period
Date of last gynecological exam
Mammogram + -
PAP + -
Form of birth control N/A
# of children
# of pregnancies
 C-section
 Surgical menopause
 Natural Menopause
Date of last menstrual cycle
Length of cycle days
Days between cycles: days

**Family Health History (Parents, Sibling, relatives)**

- Arthritis
 Asthma
 Alcoholism
 Alzheimer's disease
 Cancer
 Depression
 Diabetes
 Drug addiction
 Eating disorder
 Genetic disorder
 Glaucoma
 Heart disease
 Infertility
 Learning disabilities
 Mental illness
 Mental retardation
 Migraine headaches
 Neurological disorders (Parkinson's, paralysis, etc.)
 Obesity
 Osteoporosis
 Stroke
 Suicide
Other
 None of the above

**Health Habits**

- Water: #glasses / day / wk
 Juices: #glasses / day / wk
 Other Drink : #glasses / day / wk
 Alcohol:
Wine: #glasses / day / wk
Liquor: #glasses / day / wk
Beer: #glasses / day / wk
 Caffeine:
Coffee: #6 oz cups/d
Tea: #6 oz cups/d
Soda w/caffeine: #cans/day
Other sources
 Tobacco:
Cigarettes: #/day
Cigars: #/day

**Exercise**

- I do not work out
 I attend a gym
 I have home exer equipment / stab ball
 5-7 days per week
 3-4 days per week
 1-2 days per week
 45 minutes or more per workout
 30-45 minutes duration per workout
 Less than 30 minutes
 Cycle
 Walk
 Run, jog, jump rope
 Weight lift
 Swim
 Yoga
 Other

**Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
 Vegetarian
 Vegan
 Salt restriction
 Fat restriction
 Starch/carbohydrate restriction
 The Zone Diet
 Total calorie restriction
Specific food restrictions:
 dairy  wheat  eggs
 soy  corn  all gluten
Other

**Food Frequency(average)**

- (Servings(=palm-full size) per day:)**
Fruits (citrus, melons, etc.)
Dark green or deep yellow/orange vegetables
Grains (unprocessed)
Processed grains(bread, cereal, etc)
Beans, peas, legumes
Dairy
Eggs(how many)
Meat, poultry, fish

**Eating Habits (you may mark several)**

- Skip breakfast
 1 meal per day
 2 meals per day
 3 Meals 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**

- I do not take supplements
 Multivitamin/mineral
If yes, brand
 Vitamin C / E / A
 CoQ10
 Antioxidants (e.g., lutein, etc.)
 Omega fatty acids (EPA/DHA, etc.)
 Evening Primrose/GLA
 Calcium, source
 Magnesium, Zinc
 Minerals, describe
 Friendly flora (acidophilus)
 Digestive enzymes
 Amino acids
 Herbs
 Homeopathy
 Bach flowers
 Protein shakes
 Superfoods (e.g., bee pollen, phytonutrient blends)
 Liquid meals
 Herbs - teas
Other

**Sleeping Habits**

hours per night, usually

**I would like ASSISTANCE to:**

MUCH A Little

- Be free of pain
 Be free of numbness
 Have more energy
 Be thinner / lower body fat
 Have healthier nails / hair
 Think more clearly / focused
 Not be dependent on medications, incl. aspirin,ibuprofen, anti-histamines, sleeping aids, etc.
 Stop using laxatives / stool softener
 Reduce Digestive Problems
 Sleep better
 Get less colds and flus
 Get rid of allergies
 Have agreeable body odor
 Detoxification / Cleansing
 ADHD / Autism / Dyslexia
 Improve Sports Performance
 Reduce Fatigue
 Slow Arthritis Degeneration
 Have Pregnancy / Delivery comfort
 Reduce risk of inherited disease (e.g., cancer,heart disease, etc.)
 Other

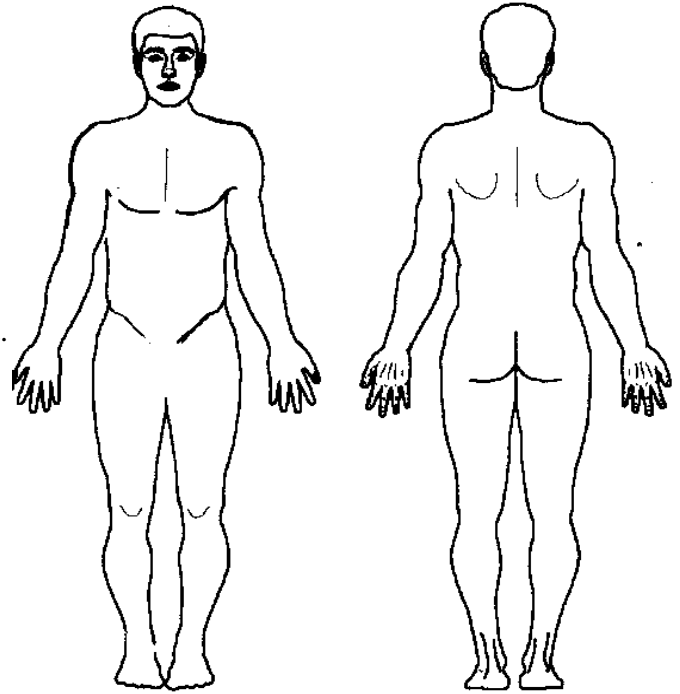
MUCH A Little

Name: DOB: Today's Date

Please mark (with a number) the sites of any **surgeries, and significant accidents, or injuries – do your best.**

Then describe it in the numbered spaces below.

You may use a number in multiple sites if the single injury involved more than one location.



**When**

**What happened and/or What for?**

Example: Jan '04 left knee cartilage surgery after football injury.

I have had no surgeries, or only (circle) Tonsils, Wisdom t.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Note: If you have a list, you may leave this blank and give us the list to copy.

I am taking no medications

Medications	What for?	When Started?	Still Taking it?	How often?
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly

Family Physician name \_\_\_\_\_

(If you approve, we'll send them a summary of our findings about you.) Sign Here if you approve: \_\_\_\_\_

**How did you decide** to come to our office (mark **ALL that affected** in your decision)

- Friend or Relative \_\_\_\_\_ (If we know who, we'll send them a "Thank You.")
- Doctor or other practitioner \_\_\_\_\_
- Insurance       Our Website       Other \_\_\_\_\_

**PATIENT AGREEMENT**

**Initial** \_\_\_\_\_ I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment.

If the health plan information is not accurately communicated by the insurance company, or if I am not eligible to receive a health care benefit through this provider, or if I need a referral from my primary physician, I understand that I am liable for all charges for services rendered. I agree to notify this doctor immediately whenever I have changes in my health plan coverage in the future.

In order to provide time for other patients to be scheduled, I will give 24-hour notice if I am not able to keep a scheduled appointment or I will be subject to a \$25.00 charge because my insurance cannot be billed for this time.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SPOUSE'S OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_