PATIENT INFORMATION

(Information contained in this form is confidential and will not be released without patient's authorization)

NAME DOB AGE DATE

Present Complaint(s)____

____

When did it first occur? Or diagnosed? ____

How long have you had the problem? ____

Have you had this in the past? ☐ Yes ☐ No When? ____

Related to: ☐ Accident ☐ Job Injury ☐ Other: ____

Pain is: ☐ Minimal ☐ Moderate ☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Shooting ☐ Severe

☐ Getting Worse ☐ Constant ☐ Comes and Goes

Rate the pain on a scale of 1-10 (1 being mild 10 being extremely painful)______________________________

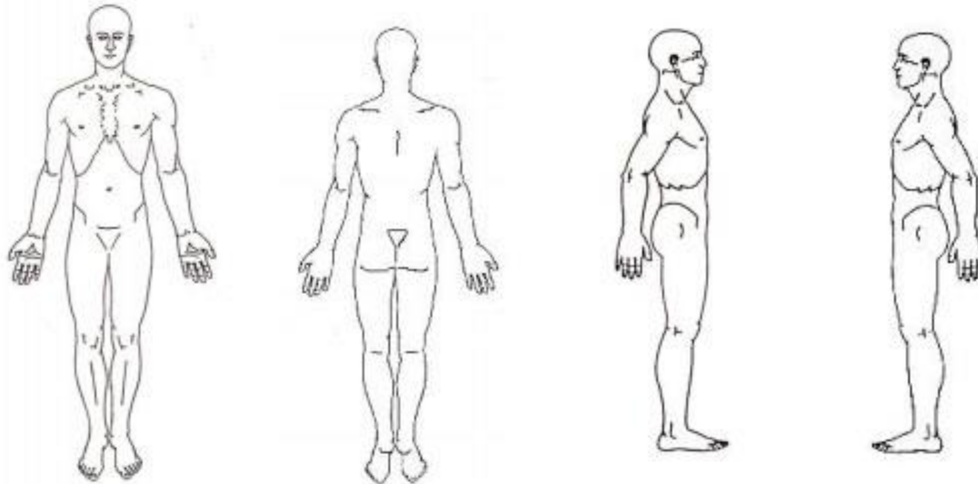
What makes your condition better? ____

What makes your condition worse? ____

Other complaint(s)? ____

List any surgeries and dates: ____

Medications/ you are taking: ____



Please mark any area(s) affected.

MEDICAL HISTORY – PLEASE CHECK WHERE APPLICABLE

SELF	**PATERNAL**	**MATERNAL**		
☐ Allergies	☐ Allergies	☐ Allergies	☐	
☐ Arthritis	☐ Arthritis	☐ Arthritis	☐	
☐ Asthma	☐ Asthma	☐ Asthma	☐	Father: Age ____
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐	Mother: Age ___
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐	
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐	How many siblings do you have?
☐ Hepatitis	☐ Hepatitis _________	☐ Hepatitis _________	☐	Sister(s) _____
☐ Cancer	☐ Cancer ___________	☐ Cancer ___________	☐	Brother(s) ___
☐ Epilepsy	☐ Epilepsy	☐ Epilepsy	☐	
☐ Stroke	☐ Stroke	☐ Stroke	☐	
☐ Other	☐ Other ____________	☐ Other ____________	☐	

Are you HIV Positive? ☐ Yes ☐ No Do you bleed easily? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

Energy level: ☐ High (time of day) ____________________ ☐ Low (time of day)____________________

Stress: ☐ None ☐ Moderate ☐ High Cause of stress: ____

Sweating: ☐ Normal ☐ Night Sweats ☐ Rarely Sweat ☐ Excess Sweating

Circulation: Feeling: ☐ Hot ☐ Cold What Area(s)?____

☐ Cold hands ☐ Cold feet ☐ Cold Limbs

☐Other:____

Sleep Problems: ☐ None ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Excessive dreaming

☐Other:____

How many hours do you sleep at night?______ Do you wake up refreshed? ☐ Yes ☐ No

Do you take Naps? ☐ Yes ☐ No

Bowels: Number of bowel movements per day. ____ ☐ Normal ☐ Loose ☐ Constipation ☐ Bloody Stools

☐ Diarrhea ☐ Mucus in Stool ☐ Hemorrhoids ☐ Foul Smelling Stools ☐ Colon Problems ☐ other____

Urine: Color ___________ Amount ☐ Normal ☐ Copious ☐ Scanty

Frequent Urination ☐ Daytime ☐ At Night ☐ Strong Smelling Urine ☐ Foul Smelling Urine ☐ Difficult Urination

☐ Painful/ burning urination ☐ Foul Smelling Urine ☐ Difficult Urination ☐ Bloody Urine ☐ Frequent Infections
Other:____

GENERAL

☐ Poor appetite	☐ Poor Sleep	☐ Fatigue	☐ Fevers
☐ Chills	☐ Night Sweat	☐ Sweat Easily	☐ Tremors
☐ Cravings	☐ Localized Weakness	☐ Poor Balance	☐ Change in Appetite
☐ Bleed/Bruise Easily	☐ Weight Gain/Loss	☐ Peculiar Taste/Smells	☐ Strong Thirst

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives/Rashes	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Loss of Hair	☐ Moles
☐ Skin Discoloration	☐ Acne	☐ Change in Skin/Hair	☐ Face Flushing
☐ Dry	☐ Moist/Clammy	☐ Burning	

HEAD, EARS, NOSE, THROAT

☐ Dizziness ☐ Difficulty Swallowing ☐ Migraines ☐ Eye Glasses
☐ Eye Strain ☐ Eye Pain ☐ Poor Vision ☐ Night Blindness
☐ Color Blindness ☐ Cataracts ☐ Blurred Vision ☐ Earaches
☐ Ringing in Ears ☐ Poor Hearing ☐ Floaters ☐ Dry Eyes
☐ Sinus Problems ☐ Nosebleeds ☐ Sore Throats/Colds ☐ Teeth Grinding
☐ Facial Pain ☐ Headaches ☐ Dental Problems ☐ Jaw Clicks/Locks
☐ Sore on Lips or Tongue ☐

CARDIOVASCULAR

☐Chest Pain ☐ Irregular Heartbeat ☐ Palpitations at Rest ☐ Fainting
☐ Cold Hands/Feet ☐ Clots ☐ Phlebitis ☐ Shortness of Breath
☐ Varicose/ Spider Veins ☐ Pressure in Chest ☐

RESPIRATORY

☐ Coughing ☐ Coughing Blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Pain with Inhalation ☐ Tight Sensation ☐ Shortness of Breath
☐ Difficulty Inhaling ☐ Difficulty Exhaling ☐ Phlegm Production ☐ Wheezing

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Gas ☐ Belching ☐ Black Stools ☐ Indigestion
☐ Bad Breath ☐ Rectal Pain ☐ Hemorrhoids ☐ Bloating
☐ Loose Stools ☐ Abdominal Pain ☐ Change in Appetite ☐ Acid Reflux
☐Hernia ☐ Heartburn ☐ Weight Gain ☐ Weight Loss

UROGENITAL

☐ Pain on Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Urgent Urination
☐ Unable to Hold Urine ☐ Kidney Stones ☐ Scanty Flow ☐ Copious Flow
☐ Impotence ☐ Sores on Genitals ☐ UTI ☐ Burning Urination
☐ Premature Ejaculation ☐ Decreased Libido ☐ Prostatitis ☐ Dribbling Urine
☐Waking to Urinate ☐ Color of Urine _________

GYNOCOLOGICAL

__ No. of Pregnancies __ Age of First Menses ☐ Ovarian Cysts ☐ Breast Lumps
__ No. of Births __ Date of Last Menses ☐ Fibrocystic Breast ☐ Irregular Menses
__ No. Miscarriages ☐ Vaginal Dryness ☐ Difficult Intercourse ☐ Endometriosis
__ No. of Abortions ☐ Vaginal Sores ☐ Infertility ☐ Fibroid Tumors
__ No. of Premature Births

Are you pregnant? ☐ Yes ☐ No
Do you practice birth control? ☐ Yes ☐ No If yes, what kind? ______________________ For how long? _________

MUSCULOSKELETAL

☐ Neck Pain ☐ Shoulder Pain ☐ Hand/Wrist Pain ☐ Carpal Tunnel
☐ Knee Pain ☐ Sprains/Strains ☐ Sciatica ☐ Foot/Ankle Pain
☐ Hip Pain ☐ Muscle Pain ☐ Muscle Weakness ☐ Tendonitis
☐ Bursitis ☐ Rotator Cuff ☐ Lower Back Pain ☐ Middle Back Pain
☐ Upper Back Pain

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Loss of Balance	☐ Vertigo/Dizziness	☐ Areas of Numbness
☐ Lack of Coordination	☐ Poor Memory	☐ Concussion	☐ Depression
☐ Anxiety/Panic Attack	☐ Bad Temper/Irritable	☐ Susceptible to Stress	☐ S.A.D

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Do you have a spiritual life? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Have you ever been treated for substance abuse? ☐ Yes ☐ No

Any other neurological or psychological conditions? ☐ Yes ☐ No

If yes, please explain: ____

____

Indicate on the scale your satisfaction in family relationships:

Satisfied ---------------------------------- Distressed

Indicate on the scale your satisfaction in intimate relationships:

Satisfied ---------------------------------- Distressed

Indicate on the scale your satisfaction in working relationships:

Satisfied ---------------------------------- Distressed

Appetite: ☐ Excessive ☐ Poor ☐ Tired or weak if meal is missed

☐ Excessive Thirst ☐ Never Thirsty Other:____

Nutrition: List some of your favorite foods ____

Food Cravings: ____

Do you: ☐ Skip Breakfast ☐ Eat a hearty breakfast ☐ Snack How many meals do you eat? __________________

When is you biggest meal? _____________ Do you eat when you are worried or rushed? ☐ Yes ☐ No

How many glasses of water do you drink?______ Do you drink alcohol? ☐ Yes ☐ No Amount per week ________

Do you use tobacco? ☐ Yes ☐ No Amount per week __________

Do you:

Eat raw fruit or vegetables at least twice a day? ☐Yes☐ No

Eat green or yellow vegetables at least twice a day? ☐Yes☐ No

Eat meat or dairy at least twice a day? ☐Yes ☐ No

Eat same food almost every day? ☐Yes ☐ No

Eat frequently between meals? ☐Yes ☐ No

Chew your food thoroughly before swallowing? ☐ Yes ☐ No

Eat until full? ☐ Yes ☐ No

Go on crash diets? ☐ Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

Drink liquids other than water? ☐ Yes ☐ No

Always add salt at the table? ☐ Yes ☐ No

Do you crave sugar or chocolate? ☐ Yes ☐ No

Patient Signature:____ Date: ____________________________