

M D Y
Date / /

Confidential Vital Information

Name _____ Age _____ Gender: M F Date of Birth M / D / Y _____

Address _____ City _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Occupation _____ How many hours per week do you work? _____

Physician _____ Emergency Contact _____ Relation _____ Phone _____

How did you hear about us? _____

Primary Concern: _____

When did this first start (be specific)? _____

What makes it better? _____

What makes it worse? _____

What do you think is causing it? _____

If your concern is pain how would you rate it from 1 to 10 (10 the most intense, 0 none) _____

Is it constant or does it come and go? _____

Any other pains? _____

Secondary Concerns?: _____

When did this first start (be specific)? _____

Have you seen an MD for your current concerns? _____ Do you have any lab or test results? _____

Do you currently see any other practitioners? _____

Have you tried any other natural/alternative therapies for these concerns? _____

Did this treatment help you? _____

List ALL past surgeries _____

List ALL past injuries _____

List ALL major illnesses _____

Current Medications _____

Past Medications _____

Current Supplements (and dosages) _____

Adverse Reactions to Medications or Vaccines _____

List any allergies that you have to foods or other substances: _____

Your Past Medical History (Please check and date)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Prostate Conditions |
| <input type="checkbox"/> Anorexia/Bulemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Infection | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pace maker | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colitis or Chron's | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraines | <input type="checkbox"/> TB |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> MS | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Parkinson's | |

Please check all symptoms that apply to you now (check) or in the past (mark with P):

General

-
- | | | | |
|---|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | |
- How would you describe your sleep? _____
- How would you describe your energy level? High ___ Moderate ___ Low ___ Up and down ___

Skin and Hair

-
- | | | | |
|---------------------------------|----------------------------------|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Loss of hair |
|---------------------------------|----------------------------------|---------------------------------|---------------------------------------|

Head, Eyes, Ears, Nose and Throat

-
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Tooth pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> "Silver" mercury tooth fillings | |

Heart and Circulation

-
- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heart beat | | | |

Lungs and Breathing

-
- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | |

Digestion and Elimination

-
- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Indigestion/Heart burn | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Chronic laxative use |
- How often do you have a bowel movement? _____ Quality? (formed, hard, soft, loose, etc.) _____
- Is your urinary frequency more than 6x/day _____
- Do you experience night time urination? _____ Number of times/night? _____

Women

- Are you Pregnant? _____ How many months? _____ Number of Children Birthed/Ages _____
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Light periods |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Changes in your body or emotions prior to menstruation? _____ | Length of Menses _____ | | |
| <input type="checkbox"/> Do you practice birth control? What type and for how long? _____ | | | |

Brain / Emotions

- Depression Anxiety Quick temper/irritable Poor memory Loss of balance
- Have you ever been treated for emotional problems?
- Any other neurological or psychological problems?

Current Stress Level 1 to 10 (10 being highest, 0 being no stress) At Work _____ At Home _____
 How long have you felt like this? At Work _____ At Home _____

What would you describe as the three dominant emotions in your life at this time? (Examples include Happiness, Fear, Sadness, Anxiety, Frustration, Anger, Grief, Heartache, Contentment, Excitement, Lethargic, Moody, Stressed, and so forth: _____

Lifestyle

Exercise

Do you exercise? _____ List type and how often _____

Habits

How much coffee do you drink per week? _____
 How much alcohol do you drink per week? _____
 How much pop do you drink per week? _____
 Do you smoke? _____ How much per day? _____
 Recreational drugs? _____ Type and how often? _____

Diet

Do you follow a specific diet? (Example: vegetarian, gluten free, macrobiotic, meat & potatoes, etc.) _____
 What do you usually eat for breakfast? _____

Family History

Please list the state of health and major illnesses that members of your family have had.
 If relevant, include at what age they died (and what they died of).

Father: _____
 Father's mother: _____
 Father's father: _____
 Mother: _____
 Mother's mother: _____
 Mother's father: _____
 Brothers and Sisters: _____
 Your children: _____
 Other family information: _____

If there is anything you would like to add, please feel free to do so. If you have any questions or concerns you would like addressed, you may write them here.
