

The information you give here will be held in the strictest confidence. Thank you for taking the time to fill out this form completely. Each item is important! Bring this form with you to your appointment on:

NAME _____ E-MAIL _____

ADDRESS _____ DATE _____

PHONE _____ HEIGHT _____ WEIGHT _____ SEX _____

AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

MARITAL STATUS _____ OCCUPATION _____

NEAREST RELATIVE OR FRIEND _____

THEIR ADDRESS _____ PHONE _____

INFORMATION REGARDING YOUR IMMEDIATE FAMILY'S HEALTH:

RELATIONSHIP:	AGE IF LIVING:	AGE AT DEATH:	STATE OF HEALTH / CAUSE OF DEATH:
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
SIBLINGS	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
SPOUSE	_____	_____	_____
CHILDREN	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

HAVE ANY BLOOD RELATIVES HAD ANY OF THE FOLLOWING ILLNESSES? IF SO, INDICATE RELATIONSHIP (FATHER, SISTER, ETC.):

ILLNESS:	FAMILY MEMBERS:
ASTHMA	_____
ALLERGIES	_____
HIGH BLOOD PRESSURE	_____
HEART DISEASE	_____
STROKE	_____
DIABETES	_____
CANCER	_____
GLAUCOMA	_____
RHEUMATOID ARTHRITIS	_____
EPILEPSY	_____
MENTAL PROBLEMS	_____
SUICIDE	_____
ALCOHOLISM	_____

GIVE THE FOLLOWING INFORMATION ABOUT ALL SERIOUS INJURIES, SURGERY AND HOSPITALIZATION YOU HAVE HAD:

YEAR:	SURGERY, ILLNESS OR INJURY:	LOCATION (TOWN):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE PETS?

IF SO, WHERE DO THEY SLEEP?

HERE IS AN EXTENSIVE LIST OF CONDITIONS. PLEASE READ EACH ONE AND IF YOU HAVE EXPERIENCED ANY OF THEM, **PROVIDE YOUR AGE** AT THE TIME AND ANY COMMENT YOU WOULD LIKE TO MAKE.

- | | |
|---------------------------------|---|
| _____ BRONCHITIS | _____ GLAUCOMA |
| _____ ASTHMA | _____ ARTHRITIS / GOUT |
| _____ DIFFICULTY INHALING _____ | _____ GALL STONES |
| _____ DIFFICULTY EXHALING _____ | _____ HEPATITIS OR JAUNDICE |
| _____ PNEUMONIA | _____ PROLONGED COURSE OF ANTIBIOTICS |
| _____ PLEURISY | _____ PROLONGED COURSE OF STEROIDS |
| _____ TUBERCULOSIS | _____ ENVIRONMENTAL / CHEMICAL INJURY |
| _____ EMPHYSEMA | _____ MULTIPLE CHEMICAL SENSITIVITY |
| _____ ECZEMA | _____ CHRONIC FATIGUE SYNDROME |
| _____ PSORIASIS | _____ FIBROMYALGIA / MYOFASCIAL PAIN SYNDROME |
| _____ HYPOGLYCEMIA | _____ CANDIDA ALBICANS OR FUNGAL INFECTION |
| _____ DIABETES | _____ MONONUCLEOSIS / EPSTEIN-BARR VIRUS |
| _____ EATING DISORDER | _____ LYME DISEASE |
| _____ HEMORRHOIDS | _____ POSITIVE HIV ANTIBODY TEST, ARC |
| _____ HERNIA | _____ AUTOIMMUNE ILLNESS _____ |
| _____ PROLAPSE | _____ CANCER OR TUMOR |
| _____ ULCER | _____ GENETIC OR HEREDITARY CONDITION _____ |
| _____ COLITIS | _____ CONCUSSION |
| _____ DIVERTICULITIS | _____ COMA |
| _____ HYPERTHYROID | _____ SEIZURE OR CONVULSION |
| _____ HYPOTHYROID | _____ EXCESSIVE DRINKING OR DRUG HABIT |
| _____ STREP THROAT | _____ MENTAL ILLNESS |
| _____ RHEUMATIC FEVER | _____ ATTEMPTED SUICIDE |
| _____ HEART MURMUR | _____ VERBAL ABUSE |
| _____ CHOLESTEROL OVER 200 | _____ PHYSICAL ABUSE |
| _____ ARTERIOSCLEROSIS | _____ BIRTH TRAUMA _____ |
| _____ HEART ATTACK | CHILDHOOD DISEASE: |
| _____ STROKE | _____ CHICKEN POX |
| _____ BLADDER INFECTION | _____ MEASLES, GERMAN _____, RED _____ |
| _____ KIDNEY INFECTION | _____ MUMPS |
| _____ KIDNEY STONES | _____ SCARLET FEVER |
| _____ PROTEIN IN URINE | _____ POLIO |

WHEN WAS THE LAST TIME YOU HAD THE FLU? _____

DATE OF MOST RECENT DENTAL WORK: _____ YEARS OF MILITARY SERVICE: _____

HAVE YOU RECENTLY HAD CHANGES IN YOUR...? :

IF YES, PLEASE EXPLAIN:

- | | | |
|------------------|-----|-------|
| MARITAL STATUS | YES | _____ |
| JOB OR WORK | YES | _____ |
| RESIDENCE | YES | _____ |
| FINANCIAL STATUS | YES | _____ |

PLEASE DESCRIBE ANY OTHER MAJOR STRESSORS IN YOUR LIFE?

HAVE YOU EVER WORKED OR SPENT TIME...? (circle)

IF SO, FOR HOW LONG?

- | | | |
|------------------------------------|-----|-------|
| ON A FARM | YES | _____ |
| IN A MINE, LAUNDRY OR MILL | YES | _____ |
| IN A DAMP, MOLDY PLACE | YES | _____ |
| IN A VERY DUSTY PLACE | YES | _____ |
| WITH OR NEAR ASBESTOS | YES | _____ |
| WITH OR NEAR RADIOACTIVE CHEMICALS | YES | _____ |
| WITH OR NEAR OTHER TOXIC CHEMICALS | YES | _____ |

Here is an extensive list of symptoms. Please read each one and put a check by it if you experience it either **now** or if it is **common** for you:

- CHILLS
 - FEVER
 - DISLIKE OF WIND
 - DISLIKE OF HEAT
 - DISLIKE OF COLD
 - SNEEZING
 - RUNNY NOSE
 - EXCESS MUCUS / CONGESTION
 - LOSS OF SENSE OF SMELL
 - LOSS OF SENSE OF TASTE
 - SINUS BLOCKAGE
 - SINUS INFECTION
 - NOSEBLEED
 - COUGH THAT IS PRODUCTIVE
 - COUGH THAT IS DRY
 - CHRONIC COUGH
 - COUGHING BLOOD
 - CHEST: TIGHT / FULLNESS
 - SHORTNESS OF BREATH
 - VERY DRY SKIN
 - ITCHY SKIN
 - FUNGUS INFECTION OF SKIN
 - RASH / HIVES
 - ACNE / BOILS
 - MOLES CHANGING IN SIZE OR IN COLOR
 - SORES HEALING SLOWLY
 - LYMPH NODES ENLARGED
 - LUMPS UNDER SKIN
 - GURGLING IN ABDOMEN
 - GAS
 - DIARRHEA:
 - “ WATERY
 - “ URGENT
 - “ IN EARLY MORNING
 - CONSTIPATION
 - BOWEL MOVEMENT PAINFUL
 - PAIN IN ABDOMEN
 - GRIEF

 - ANEMIA
 - HIGH BLOOD PRESSURE
 - LOW BLOOD PRESSURE
 - CHEST PAIN
 - PALPITATIONS
 - DIZZINESS
 - FAINTING
 - SORE THROAT
 - COLD SORES: ON LIPS / TONGUE / IN MOUTH
 - RESTLESS SLEEP
 - INSOMNIA
 - VIVID DISTURBING DREAMS
 - PANIC ATTACKS
 - ANXIETY
 - HIGH STRUNG
- LOSS OF APPETITE
 - EXCESSIVE APPETITE
 - LACK OF THIRST
 - EXCESSIVE THIRST
 - DRY MOUTH
 - LOSS OF WEIGHT
 - WEIGHT GAIN
 - PREFER: HOT / COLD DRINKS
 - DIFFICULTY SWALLOWING
 - NAUSEA / VOMITING
 - BELCHING
 - JAW PAIN
 - STOMACH ACHE
 - HEARTBURN
 - ABDOMEN BLOATED
 - GUMS: SWOLLEN / BLEEDING
 - EDEMA (SWELLING):
 - “ WHOLE BODY
 - “ UPPER BODY / NECK
 - “ LOWER BODY / ANKLES
 - BLOOD IN STOOL
 - UNDIGESTED FOOD IN STOOL
 - BLACK STOOL
 - PALE STOOL
 - BRUISING EASILY
 - WASTING MUSCLES
 - WEAK MUSCLES
 - TIRING EASILY
 - TIRED IN MORNING
 - TIRED IN AFTERNOON
 - GENERAL LETHARGY
 - WORRY
 - COMPULSIVENESS
 - OBSESSIVENESS
 - CAN'T SETTLE MIND

 - URINARY FREQUENCY
 - PAIN ON URINATION
 - DARK URINE
 - REDDISH URINE
 - CLOUDY URINE
 - BURNING URINATION
 - UP AT NIGHT TO URINATE
 - LOSING URINE ON STRAINING
 - SWEATING DURING THE DAY,
 - SWEATING WHEN AT REST
 - SWEATING AT NIGHT
 - LACK OF SWEATING
 - RESTLESS LEGS
 - LEG CRAMPS: NIGHT / DAY
 - UNSTEADY ON FEET
 - COORDINATION PROBLEMS
 - NERVE PAIN

 - HARD TO EXPRESS FEELINGS
 - FORGETFULNESS
- PAIN IN RIBS OR SIDES
 - BREAST PAIN
 - BRITTLE, SPLITTING NAILS
 - WEAK HAND GRASP
 - NECK: STIFF / PAINFUL
 - SHOULDER: STIFF/ PAINFUL
 - JOINTS: SWOLLEN / PAINFUL
 - PAINFUL TO RAISE ARM
 - LOOSE JOINTS
 - HEADACHE / MIGRAINE
 - EYE / VISION PROBLEMS:
 - “ BLURRY / DOUBLE VISION
 - “ NEAR / FAR SIGHTED
 - “ RINGS AROUND LIGHTS
 - DRY / ITCHY EYES
 - WATERY EYES
 - THROAT FEELS OBSTRUCTED
 - INTOLERANCE OF CHEMICALS
 - SHAKING OF LIMBS, BODY
 - VARICOSE VEINS
 - MUSCLE SPASMS
 - NUMB HANDS OR FINGERS
 - NUMB LEGS OR FEET
 - OTHER NUMBNESS _____
 - BITTER TASTE IN MOUTH
 - GENITAL PAIN / PROBLEM
 - MOODINESS
 - ANGER
 - IRRITABILITY
 - LONELY
 - DEPRESSION
 - BOREDOM
 - TROUBLE RELAXING
 - INDECISIVENESS

 - ODD GROWTH AS A CHILD
 - INCOMPLETE BONE FORMATION
 - DIMINISHED SEX DRIVE
 - INCREASED SEX DRIVE
 - INABILITY TO CONCEIVE
 - IMPOTENCE
 - URETHRAL DISCHARGE
 - COLD HANDS AND FEET
 - OSTEOPOROSIS
 - STIFF SPINE
 - UPPER BACK PAIN
 - MIDDLE BACK PAIN
 - LOWER BACK PAIN
 - HIP PAIN: RIGHT / LEFT
 - KNEE PAIN: RIGHT / LEFT
 - TEETH PROBLEMS
 - HAIR LOSS
 - LOSS OF HEARING
 - RINGING IN EARS
 - FEAR
 - DREAD

HAVE YOU TRAVELED OUTSIDE THE U.S. IN THE LAST TWO YEARS? YES / NO

IF YES, WHERE DID YOU TRAVEL? _____

CHECK THE INOCULATIONS YOU HAVE HAD:

FLU ____ ROTAVIRUS ____ TETANUS ____ TYPHOID ____ DIPHTHERIA ____ POLIO ____
YELLOW FEVER ____ HEPATITIS A ____ B ____ OTHER: _____

HAVE YOU HAD A POSITIVE _____ OR NEGATIVE _____ TUBERCULIN (TB) TEST?

NO YES QUANTITY

DO YOU SMOKE CIGARETTES? _____
DO YOU USE MARIJUANA? _____
DO YOU USE HARD DRUGS? _____
DO YOU DRINK ALCOHOL? _____
DO YOU DRINK CAFFEINATED DRINKS? _____

DO YOU FEEL YOU HAVE AN ADDICTION TO ANY OF THE ABOVE SUBSTANCES? YES / NO

IF YES, WHICH ONES? _____

HOW MUCH DO YOU EXERCISE? LITTLE OR NONE / 1 – 3 TIMES PER WEEK / OVER 3 TIMES PER WEEK

WHAT TYPES OF EXERCISE OR SPORTS DO YOU ENJOY? _____

WOMEN, please answer the following questions:

AGE AT ONSET OF MENSTRUAL PERIODS (MOONS): _____
USUAL NUMBER OF DAYS IN MONTHLY CYCLE: _____
USUAL DURATION OF BLOOD FLOW: _____ DAYS
APPROXIMATE DATE OF LAST MENSTRUAL PERIOD: _____

GIVE YOUR AGE WHEN YOU MAY HAVE EXPERIENCE ANY OF THE FOLLOWING CONDITIONS:

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS ON YOUR MONTHLY CYCLE?

____ EMOTIONAL UPS AND DOWNS
____ DEPRESSION
____ IRRITABILITY
____ CRAVING OF SWEETS / SALT
____ SKIN ERUPTIONS
____ WATER RETENTION / BLOATING
____ WEIGHT GAIN
____ NAUSEA / VOMITING
____ CONSTIPATION / DIARRHEA
____ SWELLING OF BREASTS/TENDERNESS
____ PAINFUL CRAMPS / ABDOMINAL PAIN
____ LOW BACK ACHING
____ EXCESS BLEEDING / CLOTS OR DARK FLOW
____ SPOTTING / IRREGULAR PERIODS
____ SKIPPED MENSTRUAL PERIOD

____ YEAST INFECTION
____ VAGINAL IRRITATION
____ PAINFUL INTERCOURSE
____ BREAST INFLAMMATION
____ OVARIAN CYST
____ UTERINE FIBROID(S)
____ IRREGULAR PAP SMEAR
____ PELVIC INFLAMMATORY DISEASE
____ ENDOMETRIOSIS
____ HYSTERECTOMY, cause _____

NUMBER OF PREGNANCIES _____
NUMBER OF MISCARRIAGES _____
NUMBER OF ABORTIONS _____
ECTOPIC PREGNANCIES _____
NUMBER OF CHILDREN _____
ARE YOU PREGNANT NOW? _____
DO YOU EXAMINE YOUR BREASTS FOR LUMPS REGULARLY? _____

HISTORY OF BIRTH CONTROL (PILLS, IUD, DIAPHRAGM, ETC.): _____

IF APPLICABLE, AGE AT MENOPAUSE: _____ LIST ANY MENOPAUSAL SYMPTOMS: _____

MEN, please answer the following questions:

DO YOU EVERY HAVE PAIN, LUMPS OR SWELLING IN YOUR TESTICLES? _____

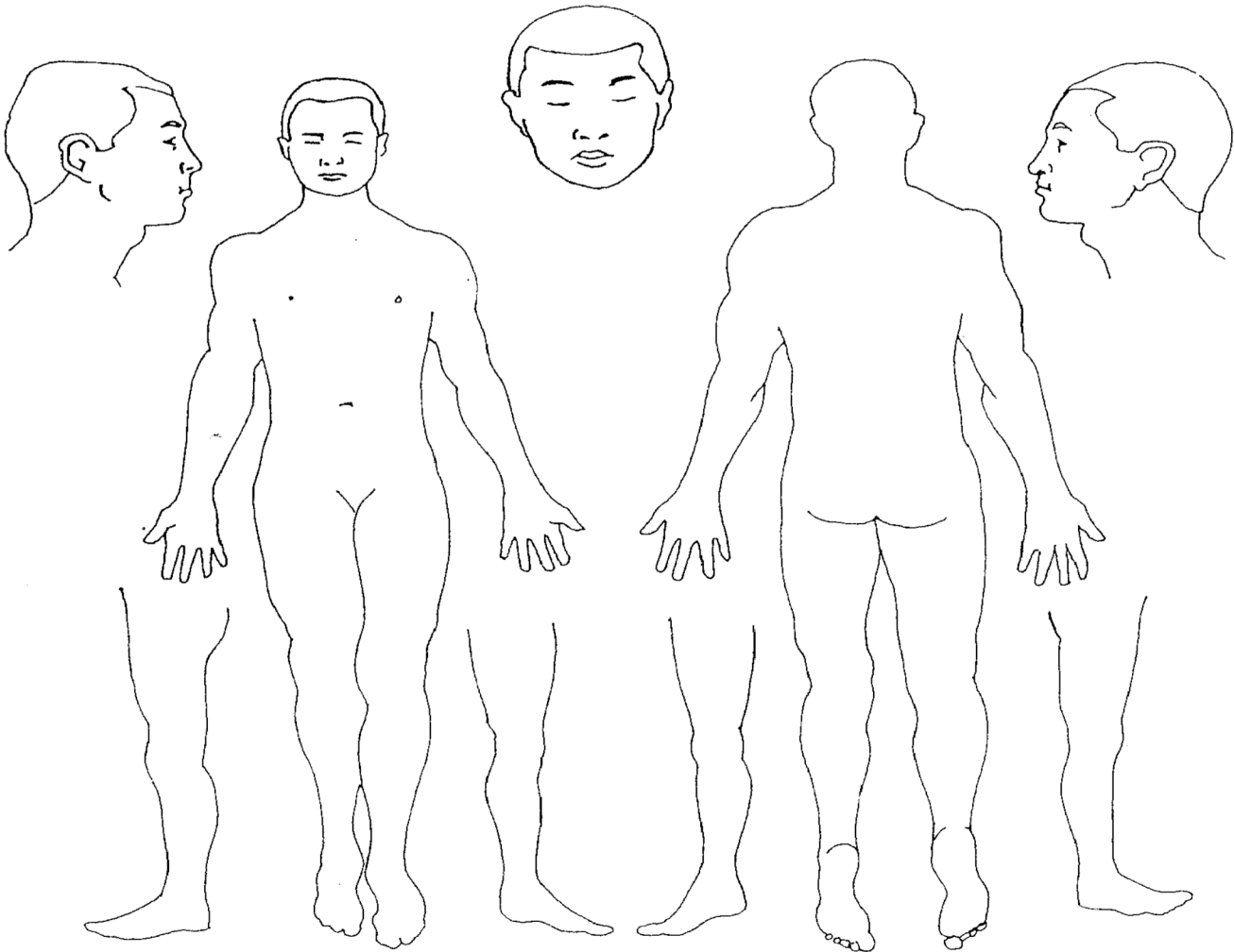
HAVE YOU HAD OR DO YOU HAVE AN ENLARGED PROSTATE? _____ PSA TEST LEVEL? _____

HAVE YOU HAD A VASECTOMY AND IF SO, WHEN? _____

PRESENT FORM OF BIRTH CONTROL: _____

List all items to which you are allergic (foods, pollens, dust, drugs, chemicals, soaps, perfume, animals, bee stings, etc.) and indicate the reaction:

On the figures below, please mark any areas where you experience pain or discomfort:



EXPLANATIONS: _____

WHAT FOODS DO YOU CRAVE? _____

