

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(S) \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
home work cell zip

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.): IF YOU WERE ADOPTED, NOTE AGE \_\_\_\_\_

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):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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                            |
| _____ ARTERIOSCLEROSIS          | _____ PHYSICAL ABUSE                          |
| _____ HEART ATTACK              | _____ BIRTH TRAUMA _____                      |
| _____ STROKE                    | CHILDHOOD DISEASE:                            |
| _____                           | _____ 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? \_\_\_\_\_

YEARS OF MILITARY SERVICE: \_\_\_\_\_

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

IF YES, PLEASE EXPLAIN:

- |                  |     |       |
|------------------|-----|-------|
| MARRIAGE/PARTNER | YES | _____ |
| JOB OR WORK      | YES | _____ |
| RESIDENCE        | YES | _____ |
| FINANCIAL STATUS | YES | _____ |

PLEASE DESCRIBE ANY OTHER MAJOR STRESSORS IN YOUR LIFE?

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU EVER LIVED OR WORKED...? (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
  - SLEEP APNEA
  - 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

DATE OF MOST RECENT DENTAL WORK: \_\_\_\_\_ NUMBER OF ROOT CANALS \_\_\_\_\_

OTHER SYMPTOMS: \_\_\_\_\_

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 CANNABIS? \_\_\_\_\_  
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:

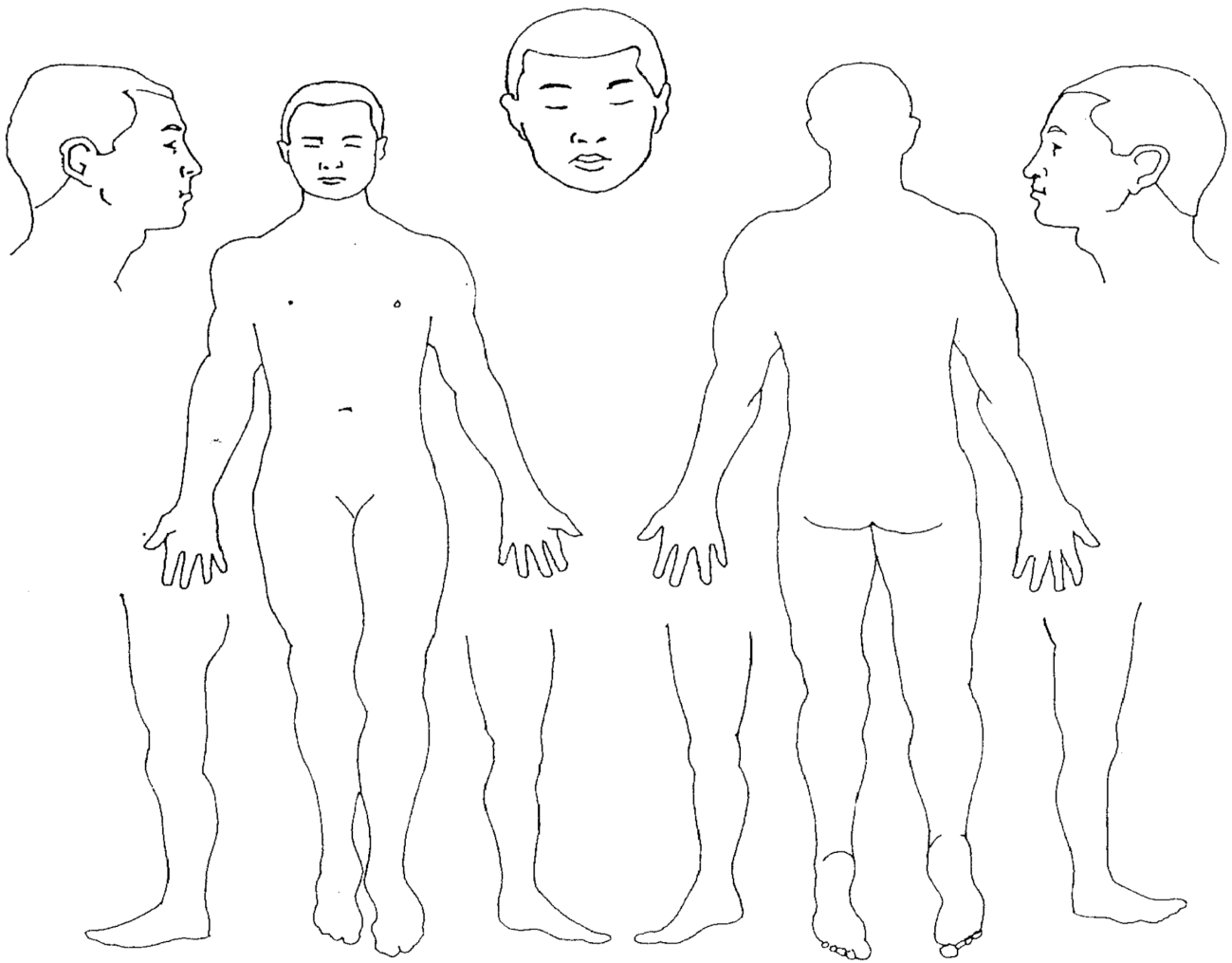
DO YOU EVERY HAVE PAIN, LUMPS OR SWELLING IN YOUR TESTICLES? \_\_\_\_\_

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: \_\_\_\_\_

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



EXPLANATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

WHAT FOODS DO YOU CRAVE? \_\_\_\_\_

WHAT FOODS DO YOU AVOID? \_\_\_\_\_

\_\_\_\_\_

