Patient History

Date: _____ Date of Injury (DOI) _____

Patient Name _____ DOB ____/_____/_____ Age_____ Male___ Female ___

M_____ F_____ Height _____Weight_____ Handedness: R ___ L ___ A ___ Race _____

What is the reason for your visit today? _____

_____

_____

How, when, and where did this condition(s) begin?_____

_____

What types of treatments and/or medications have you tried for this condition(s), if any?

_____

_____

How does this condition(s) impair your daily activities?_____

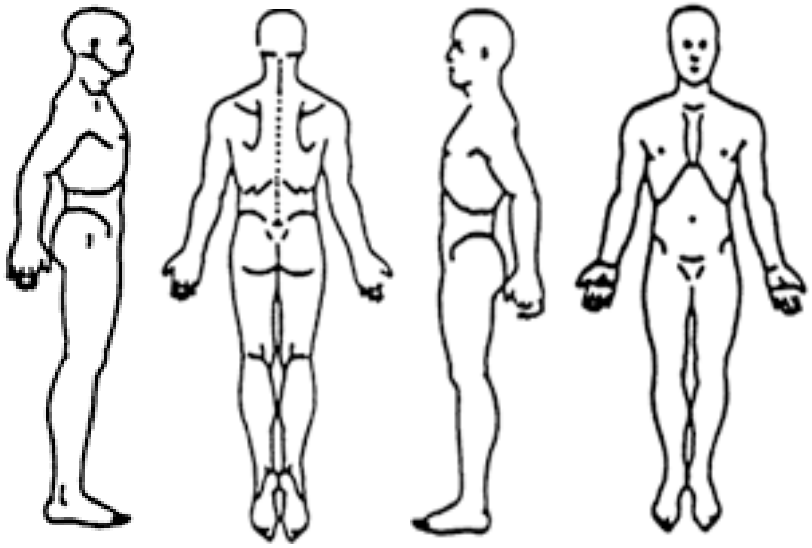
What Makes it Better? _____

What Makes it Worse? _____

Please list your main health problems you would like to address in order of importance:

1. _____
2. _____
3. _____

Please mark all areas of pain on the diagram:



<u>HEALTH & MEDICAL HISTORY</u>

Have you been under care with any health care provider(s) in the last year? Yes ____No ____

If yes, please provide names and phone numbers: _____

_____

What, if any, contagious disease do you have at this time?_____

Patient History

Patient Name_____ **Date of Birth**_____

What childhood illnesses have you had? _____

Please list surgeries, major illnesses, hospitalizations, and major accidents (include dates):

_____

_____

What allergies to drugs or food do you have? _____

What current medications do you take and for what?_____

_____

Chronic or continuing illnesses_____

Health and emotional state throughout your childhood _____-

Please list any vitamins / supplements you are currently taking or medications taken in the past

_____

_____

LIFESTYLE

Do you exercise? Yes _____No _____ Number of times/week: _____ Type of exercise:

_____

What is your daily diet like? Please include beverages (coffee, tea, alcohol, etc.)

Breakfast_____

Lunch_____

Dinner_____

Snack_____

How many glasses of water do you drink a day? _____ Do **you enjoy your work? Yes _____No _____**

Why? _____

Do you have trouble falling asleep? Yes _____No _____Time to bed _____ Time to rise _____

How many hours of sleep do you get per night? _____ Are you rested in the morning? Yes _____No _____

Do you wake during the night? Yes _____No _____Approximately what time? _____

Do you often awake more than 1X / night to urinate? Yes _____No _____

Are you a former smoker? Yes _____No _____ How many packs per day? _____

Are you a current smoker? Yes _____No _____ How many packs per day? _____

Interests and Hobbies_____

Is there anything else I should know?_____

_____

FAMILY HISTORY

Age (if living) **____Father ____Mother ____Brother ____Sister ____Spouse ____ ____ Child(ren)**

Health (G=good P=poor) **____Father ____Mother ____Brother ____Sister ____Spouse ____ ____ Child(ren)**

Patient History

Patient Name_____ **Date of Birth**_____

Systems review (Please number all that apply below):

0=Never 1=rarely 2=occasionally 3=frequently 4=always

____ Spontaneous sweat	____ Asthma	____ Dry nose/mouth/throat
____ Fatigue	____ Shortness of breath	____ Nasal discharge
____ Allergies	____ General weakness	____ Feel worse after exercise
____ Catch colds easily	____ Cough	____ Sinus congestion

____ Nightmares	____ Insomnia	____ Chest pain traveling
____ Chest pain	____ Headaches	to shoulder
____ Feel Heart Beating	____ Sores on tip of tongue	Overall body temperature
____ Feel Low in Spirits	____ Restlessness	___ High ____Med ___ Low

____ Digestive problems	____ Acid reflux	____ Gums (bleeding/swollen)
____ Prone to worry	____ Mouth sores	____ Thirst
____ Low appetite	____ Fatigue after eating	____ Organ prolapsed
____ Ravenous appetite	____ Gas/bloating after food	(diagnosed)
____ Loose stools	____ Bruise easily	____ Belching/vomiting

____ Often sick/have allergies	____ Pain worse w/rain	____ Heavy sensation
____ Crave sweets	____ Overweight	____ Foul smelling stools
____ Tired after meals	____ Acne	____ Dizziness
____Dry mouth/throat	____Excessive sweating	____Thirsty for cold drink

____Symptoms worse with	____Tight feeling in chest	____Anger easily
stress	____Dry eyes	____Neck/shoulder tension
____Irritable	____Alt. diarrhea/constipation	____Red eyes
____Breast tenderness	____Ear ringing	____Feel better after exercise
____Numb extremities	____Muscle twitches/spasms	____Do you feel warm

____Dry skin	____Dizziness/lightheaded	
____Brittle nails	____See floaters	____Loosening or thinning hair
____Premature grey hair	____Low back pain	____Night sweats
____Morning diarrhea	____Edema	____Ear problems
____Sore, cold or weak knees	____Frequent urination	____Hot flashes
____Feel cold	____Urinary incontinence	____Pain better with heat
____Face flush	____Afternoon fever	Hair loss Yes _____No _____
____Impaired memory	Libido-High__ Normal__ Low__	
____Heat in palms or soles	Infertility Yes _____No _____	

Patient History

Patient Name_____ **Date of Birth**_____

Systems review (Please number all that apply below):

0=Never 1=rarely 2=occasionally 3=frequently 4=always

Urination: Please check (√) any of the following symptoms you are currently experiencing.

____Burning ____Urgent ____Retention ____Insufficient

____Profuse ____Dribbling ____Up to urinate more than 1x a night

Bowel Movement: Please check (√) any of the following that apply.

Frequency: _____ When? _____ Feels complete? Yes _____No _____

Consistency: ____Well-formed ____Hard ____Loose ____Alternating

Stools: ____ Undigested food ____Blood ____Mucus

WOMEN ONLY

Age of your first period_____ Date of last menstrual cycle _____ Average # days of flow _____

Days from the start of one period to the start of the next _____ Are you pregnant now? Yes _____No _____

Are you currently on birth control? Yes _____No _____If yes, what kind?_____

For the following please circle:

Are your menstrual cycles spaced regularly? Yes _____No _____

Flow is: ___ Light___ Normal___ Heavy Color is: ___Light red ____Red ___Dark Red ___ Purple ___ Brown

Do you have blood clots? Yes _____No _____

Do you pain or cramping with period? Yes _____No _____If yes, Before ___During ___After period ____

Do you have breast lumps? Yes _____No _____ Fibrocystic breasts? Yes _____No _____

Do you experience any of the following before your period each month?

Water retention _____Breast tenderness or swelling _____ Mental depression _____ Irritability _____

Food cravings _____ Migraines _____Other_____

Number of pregnancies: _____# of abortions: _____# of live births: _____# of miscarriages: _____

Are you in menopause? Yes _____No _____If you are experiencing menopausal symptoms, please describe

_____

Anything Else_____

MEN ONLY

Been diagnosed with prostate problems? Yes _____No _____

Do you experience premature ejaculation? Yes _____No _____

Do you have problems with impotence? Yes _____No _____

Have you been diagnosed with infertility? Yes _____No _____

Diseases/disorders:_____

_____

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.