

Please answer these questions as accurately as possible so that we may be able to most effectively assist you in reaching and maintaining optimum wellness. Due to the fact that health issues are often influenced by many factors, the more carefully you consider these questions, the better we will be able to make use of your scheduled consultation time, the more effective we will be at providing you with superior care, and the greater ability we will have to formulate an accurate treatment plan for you.

FIRST NAME	MIDDLE NAME	LAST NAME
BIRTH DATE	AGE	BIRTHPLACE (CITY/TOWN & COUNTRY IF NOT U.S.)
WHERE DID YOU SPEND MOST OF YOUR LIFE GROWING UP?		
SEX	OCCUPATION	
REFERRED BY	HOW DID YOU HEAR ABOUT US?	TODAY'S DATE

I. Please check all that apply:

African American
 Asian
 Caucasian
 Hispanic
 Mediterranean
 Native American
 Northern European
 Pacific Islander
 Other _____

II. When did you last feel optimally well? This time must precede any diagnosis of illness and/or any prescribed medications. _____

III. Please rank current and ongoing problems by **priority** and **severity** – while also filling in the other boxes as completely as possible:

PROBLEM	SEVERITY	TREATMENT	SUCCESS
Example: Headache	Moderate	Acupuncture	Moderate
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

IV. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
1. Anemia		
2. Arthritis		
3. Asthma		
4. Bronchitis		
5. Cancer		
6. Chronic Fatigue Syndrome		
7. Crohn's Disease or Ulcerative Colitis		
8. Diabetes		
9. Emphysema		
10. Epilepsy, Convulsions, or Seizures		
11. Gallstones		
12. Gout		
13. Heart Attack/Angina		
14. Heart Failure		
15. Hepatitis		
16. High Blood Fats (cholesterol, triglycerides)		
17. High Blood Pressure (hypertension)		
18. Irritable Bowel		
19. Kidney Stones		
20. Mononucleosis		
21. Pneumonia		
22. Rheumatic Fever		
23. Sinusitis		
24. Sleep Apnea		
25. Stroke		
26. Thyroid Disease		
27. Other (describe)		

INJURIES	WHEN	COMMENTS
28. Back Injury		
29. Broken (describe)		
30. Head Injury		
31. Neck Injury		
32. Other (describe)		

DIAGNOSTIC STUDIES	WHEN	RESULTS
33. Barium Enema		
34. Bone Scan		
35. CAT Scan of Abdomen		
36. CAT Scan of Brain		
37. CAT Scan of Spine		
38. Chest X-ray		
39. Colonoscopy		
40. EKG		
41. Liver Scan		
42. Neck X-ray		
43. NMR/MRI		
44. Sigmoidoscopy		
45. Upper GI Series		
46. Other (describe)		

OPERATIONS	WHEN	COMMENTS
47. Appendectomy		
48. Dental Surgery		
49. Gall Bladder		
50. Hernia		
51. Hysterectomy		
52. Tonsillectomy		
53. Other (describe)		
54. Other (describe)		

V. Hospitalizations:

WHERE HOSPITALIZED	WHEN	REASON
1.		
2.		
3.		
4.		
5.		

VI. How often have you have taken antibiotics?

	< 5 TIMES	> 5 TIMES
Infancy / Childhood		
Teen		
Adulthood		

VII. What medications are you taking now? Include non-prescription drugs.

MEDICATION NAME	DATE STARTED	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

VIII. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

VITAMIN / MINERAL / SUPPLEMENT NAME	DATE STARTED	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

IX. **Family History:** For each member of your family, follow the line across the page and check the boxes for their present state of health and any illnesses they have had:

<p>PRINT NAMES BELOW</p> <p>Note: Except for spouse, Family refers to blood or natural relatives.</p>	Good Health	Poor Health	Deceased	Write in age and cause of death, including accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Disease	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer	
Father:																				
Mother:																				
Siblings:																				
Spouse:																				
Child:																				
Child:																				
Child:																				
Child:																				
Child:																				
Paternal relatives*																				
Maternal relatives*																				

* In each box, please write in how many affected with condition.

X. Please check if these symptoms occur presently or have occurred in the past 6 months:

GENERAL:	MILD	MEDIUM	SEVERE
Fatigue (AM, PM, constant)			
Difficulty Sleeping			
Cold Intolerance			
Cold Hands and Feet			
Hot Intolerance			

HEAD, EYES, EARS:	MILD	MEDIUM	SEVERE
Headaches			
Migraines			
Ear Problems			
Eye Problems			
Hearing Problems			
Vision Problems			
Sensitivity to Smells			

MUSCULOSKELETAL:	MILD	MEDIUM	SEVERE
Back Pain			
Joint Pain			
Muscle Pain			
Muscle Cramps			
Limited Range of Motion			
TMJ Problems			

MOOD/NERVES	MILD	MEDIUM	SEVERE
Anxiety			
Panic Attacks			
Depression			
Suicidal Thoughts			
Difficulty Concentrating			
Difficulty with Memory			
Irritability			
Dizziness			
Light-Headed			
Numbness			
Seizures			
Tremors			
Hallucinations			

EATING:	MILD	MEDIUM	SEVERE
Anorexia			
Bulimia			
Can't Lose Weight			
Weight Distribution			
Can't Gain Weight			
Carb/Sugar Cravings			
Salt Cravings			
Chocolate Cravings			
Loss of Appetite			

DIGESTION	MILD	MEDIUM	SEVERE
Canker Sores			
Bad Teeth			
Cracking Corners of Mouth			
Bleeding Gums			
Bloating/Gas			
Blood in Stools			
Black Stools			
Constipation			
Diarrhea			
Undigested Food in Stool			
Difficulty Swallowing			
Reflux/Heartburn			
Hemorrhoids			
Intolerance to Dairy			
Intolerance to Gluten/Wheat			
Intolerance to Corn			
Intolerance to Eggs			
Intolerance to Fatty Foods			
Jaundice			
Liver Problems			
Abdominal Pain			
Nausea/Vomiting			

SKIN & NAILS:	MILD	MEDIUM	SEVERE
Acne			
Dry Skin			
Cellulitis/Folliculitis			
Rash			
Skin Sensitivities			
Eczema			
Psoriasis			
Herpes			
Easy Bruising/Bleeding			
Skin Cancer			
Vitiligo			
Itchy Skin			
Brittle Nails			
Nail Changes			

RESPIRATORY:	MILD	MEDIUM	SEVERE
Cough			
Shortness of Breath			
Wheezing			
Asthma			
Sinus Problems			
Post Nasal Drip			
Snoring			

CARDIOVASCULAR:	MILD	MEDIUM	SEVERE
Chest Pain/Angina			
Heart Attack			
Heart Murmur			
High Blood Pressure			
Irregular Pulse			
Mitral Valve Prolapse			
Palpitations			
Swollen Ankles/Feet			

URINARY:	MILD	MEDIUM	SEVERE
Infection			
Kidney Disease/Stones			
Incontinence			
Pain/Burning			
Urgency			

REPRODUCTIVE MALE:	MILD	MEDIUM	SEVERE
Prostate Problems			
Penile Discharge			
Infections			
Impotence			
Ejaculation Problems			
Low Sex Drive/Libido			

REPRODUCTIVE FEMALE:	MILD	MEDIUM	SEVERE
Breast Problems			
Ovarian Problems			
Low Sex Drive/Libido			
Endometriosis			
Fibroids			
Vaginal Problems			
Infertility			
Night Sweats			
Hot Flashes			

PREMENSTRUAL SYMPTOMS:	MILD	MEDIUM	SEVERE
Breast Tenderness			
Bloating			
Food Cravings			
Constipation			
Diarrhea			
Sleep Problems			
Fatigue			
Irritability			

MENSTRUAL PROBLEMS:	MILD	MEDIUM	SEVERE
Cramps			
Heavy Flow			
Irregular Menses			
No Periods			
Spotting Between			