Name: ______________________________ Preferred Name: _________________

Date of Birth: ____________ Email: ______________________________________

Street Address: ____

City: _______________________________ State:____________ Zip:____________

Preferred Phone:________________________ Okay to leave message? _________

Social Security Number: ______________________

Insurance Company:______________Policy #:___________Group #:___________

Name of Insured: _________________ Relation to Insured: __________________

Person to call in case of Emergency: ______________________________________

Relationship to you: _________________ Phone number: ___________________

Are you currently receiving healthcare elsewhere? Y / N

Please list your health care team: _______________________________________

____

Last blood work and where it was drawn: __________________________________

List your single most important health concern (we will review all symptoms from head to toe): ____

How committed are you to making changes? ______________________________

Social

Sex assigned at birth: ____

Gender: ____

Sexual Orientation: ____

Marital Status (circle):

Single Married Separated Divorced With Partner Widow(er) Polyamorous

Do you have any children? Y / N

If yes, please list their ages: ____

Other home-mates? ____

Pets? ____

Please Circle

- **Y** if you have the problem **NOW**
- **N** if you've **NEVER** had the problem
- **P** if you had the problem in the **PAST**, especially if it has happened repeatedly or was severe.

What activities bring you joy? ____

Who are your social supports? ____

What are your favorite forms of movement? ______________________________

Job/Career: ____________________________________Do you enjoy it? _____

Spiritual practice: Y N P ____________________________________

Abuse by partner: Y N P ____________________________________

Abuse by parent: Y N P ____________________________________

Abuse by other: Y N P ____________________________________

Mental health therapy: Y N P ____________________________________

Family History

Please list family members with these conditions. Limit to parents, children, siblings and grandparents.

Alcohol/Addiction ____

Allergies/Asthma ____

Autoimmune disease ____

Cancers ____

Diabetes ____

Heart Disease/Hypertension/Stroke ______________________________

Mental Illness ____

Other ____

Past Medical History

List All Surgeries, Accidents, and Hospitalizations - including date occurred

____ Date: ___________

____ Date: ___________

____ Date: ___________

X-rays: ____

MRI/CT Scans:____

Ultrasounds:____

Please List All Sensitivities/Allergies/Reactions:
Drugs: ____
Foods: ____
Environmental: ____

Vaccines:

- standard childhood vaccinations for your age group? _________________
- travel vaccinations? ____
- yearly flu vaccinations? ____
- Any unusual reactions to vaccinations? ____________________________

List all Prescription Medicine, Over-The-Counter medicine, Supplements, Herbs, Homeopathy, Vitamins you are taking, including dose. ***Please bring the bottles of anything you're taking to your first appointment***:

Supplements:	Medications:
______________________________________	___________________________
______________________________________	___________________________
______________________________________	___________________________
______________________________________	___________________________
______________________________________	___________________________
______________________________________	___________________________
______________________________________	___________________________

Steroids: Y N P Analgesics: Y N P
Coffee: Y N P……………...Ounces: ______________________________
Soda Pop: Y N P……………...Ounces: ______________________________
Alcohol: Y N P……………...Qty/Freq: ______________________________
Smoking: Y N P……………...# per day: _____________________________
Cannabis: Y N P……………...Frequency: _____________________________
Other drugs: Y N P……………...Frequency: _____________________________

Have you had a significant weight or size increase or decrease? Y N P

Food restriction	Y N P	History of dieting	Y N P
Eating when not hungry	Y N P	Eating beyond comfort	Y N P
Skipping meals	Y N P	Poor Appetite	Y N P
Intentional vomiting	Y N P	Laxatives:	Y N P

Using substances to suppress hunger Y N P ___________________________
Food cravings: ____
Foods that don't sit well:____
Foods that you avoid: ____

Sleep/Energy:

What hours do you sleep?: ____

Difficulty falling asleep:	Y N P	Difficulty staying asleep:	Y N P
Not dreaming nightly:	Y N P	Nightmares:	Y N P
Wake unrefreshed:	Y N P	Wake without hunger:	Y N P
Wake nauseous:	Y N P	Must nap during the day:	Y N P
Sleep walk:	Y N P	Grind teeth:	Y N P
Snore:	Y N P	Fatigue:	Y N P

Toxin Exposure:

Zip code where you grew up: ____

Did you grow up near known pollution? ________________________________

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:______________________________________

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing? ______________________

Do you experience symptoms with fragrances? _________________________

Do you use pesticides, herbicides, other chemicals around your home?________

Mental/Emotional:

Depression/Sadness:	Y N P	Anger/irritability:	Y N P
Suicidal	Y N P	Anxiety/Fear:	Y N P
Pharmaceuticals	Y N P	Therapy	Y N P
Hospitalization	Y N P		

Describe your:

Focus/Concentration ____

Memory/Recall ____

Comprehension ____

Skin:

Rash:	Y N P	Color Change:	Y N P
Hives:	Y N P	Lump:	Y N P
Psoriasis:	Y N P	Itchy:	Y N P
Eczema:	Y N P	Warts:	Y N P
Dry:	Y N P	Moles:	Y N P
Cancer:	Y N P	Excess sweat:	Y N P
Stretch marks:	Y N P	White spots on nails:	Y N P

Sensitive to cheap metal, shirt tags, or rough textured fabrics? Y N P

Head:

Headache:	Y N P	Migraine:	Y N P
Dandruff:	Y N P	Head Injury:	Y N P
Oil/dry hair:	Y N P	Hair loss:	Y N P

Eyes:

Dry/Watery:	Y N P	Blurry vision:	Y N P
Double vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under eyelid:	Y N P
Sens. to light:	Y N P	Poor night vision:	Y N P
Date of last Eye Exam: __________		Glasses/Contacts:	Y N P

Ears:

Earache:	Y N P	Discharge:	Y N P
Ringing:	Y N P	Hearing Changes:	Y N P
Infections:	Y N P	Dizziness:	Y N P
Sensitivity to sound:	Y N P		

Nose:

Frequent colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post nasal drip:	Y N P
Polyps:	Y N P	Seasonal allergies:	Y N P

Mouth/Throat:

Canker sores:	Y N P	Cold sores:	Y N P
Sore throat:	Y N P	Gum disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of taste:	Y N P	Hoarseness:	Y N P
Date of last Dental Exam: _________			

Neck:

Stiffness:	Y N P	Swollen glands:	Y N P
Pain:	Y N P		

Respiratory:

Cough:	Y N P	Tuberculosis:	Y N P
Bronchitis:	Y N P	Pneumonia:	Y N P
Asthma:	Y N P	Painful breathing:	Y N P
Shortness of breath with exertion:		Y N P	
Shortness of breath sitting:		Y N P	
Shortness of breath lying down:		Y N P	

Cardiovascular:

High blood pressure:	Y N P	Low blood pressure:	Y N P
Rheumatic Fever:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest pain:	Y N P

Gastrointestinal:

Heartburn:	Y N P	Bowel movement frequency:______	
Indigestion:	Y N P	Recent change in BM:	Y N P
Bloating:	Y N P	Diarrhea/constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gallbladder disease:	Y N P
Change in Appetite:	Y N P	Liver disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

Date of last Colonoscopy (if applicable): __________

Urinary Tract:

Incontinence:	Y N P	Pain:	Y N P
Frequent infections:	Y N P	Kidney stones:	Y N P
Urgency:	Y N P	Discharge/blood:	Y N P

Pelvic Organs and Breasts:

Sexually active:	Y N P	Contraception: ______________________	
Healthy Libido:	Y N P	STI/STD:	Y N P
Painful Intercourse:	Y N P	Discharge:	Y N P
Use of Hormones:	Y N P	Hernia:	Y N P
Self-breast exams:	Y N P	Breast Implants:	Y N P
Mammogram:	Y N P Date: ______________	Abnormal?: ______________	
Infertility:	Y N P	# of Pregnancies & Births: ____________	
Testicular pain:	Y N P	Age periods began:_________________	
Testicular bumps/swelling	Y N P	Freq and length: ___________________	
Self-testicular exams:	Y N P	1st day of last menses:______________	
Difficulty getting erection:	Y N P	Heavy Bleeding:	Y N P
Diff maintaining erection:	Y N P	Severe Cramping:	Y N P
Abnormal PSA:	Y N P	PMS symptoms:	Y N P
Digital Rectal Exam:	Y N P	Vaginitis:	Y N P
Prostate swelling:	Y N P	Vaginal Dryness:	Y N P
Prostatic surgery:	Y N P	Last pap date: ______________________	
Prostatic cancer:	Y N P	Abnormal Paps:	Y N P __________

Musculoskeletal:

Weakness:	Y N P	Arthritis:	Y N P
Stiffness:	Y N P	Leg cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P
DEXA/Bone Scan:	Y N P Date: ______________	Abnormal?: ______________	

Nervous:

Paralysis:	Y N P	Sciatica:	Y N P
Burning/Tingling:	Y N P	Carpal tunnel:	Y N P
Seizures:	Y N P	Fainting:	Y N P