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? __________________________________

Allergies

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

Past Medical History

Please List All Currently Diagnosed Illnesses and Conditions:
____
____
____

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

____ Date: ____________

____ Date: ____________

____ Date: ____________

X-rays: ____

MRI/CT Scans:____

Ultrasounds:____

Vaccines:

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

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 ____

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.

Social

Sex assigned at birth: ____

Gender: ____

Sexual Orientation: ____

Marital Status: ____

Do you have any children? Y / N

If yes, please list their ages: ____

Other home-mates? ____
Pets? ____
What activities bring you joy? ____
Who are your social supports? ____
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 ____
Coffee: Y N P……………Ounces: ____
Soda: 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: _______________________________________

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/Herbs/Homeopathy:	Medications/Over-The-Counter Drugs:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Sleep/Energy:

What hours do you sleep? ____

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

Toxin Exposure:

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? ____________

General

Fever	Y N P	Fatigue	Y N P
Chills	Y N P	Swollen neck glands	Y N P
Night sweats	Y N P	Poor appetite	Y N P

Diet

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

Food restriction	Y N P	Skipping meals	Y N P
Eating when not hungry	Y N P	Intentional vomiting	Y N P
Eating beyond comfort	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 ____

Diet you follow ____

Foods you eat frequently ____

How many times do you eat per day? ______________________________________

Exercise

Frequency: ______________________ Intensity: High Medium Low

Time per session: _________________ Type: _____________________________

What are your favorite forms of movement? ________________________________

Activity level: High Medium Low

Eyes

Dry	Y N P	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	Sensitivity to light	Y N P
Poor night vision	Y N P	Glasses/Contacts	Y N P

Date of last eye exam: ______________

Head

Headache	Y N P	Migraine	Y N P
Dandruff	Y N P	Head injury	Y N P
Oily hair	Y N P	Dry hair	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	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	Dentures	Y N P
Cold sores	Y N P	Cavities	Y N P
Sore throat	Y N P	Loss of taste	Y N P
Gum disease	Y N P	Hoarseness	Y N P

Date of last dental exam: __________

Respiratory

Cough:	Y N P	Pneumonia:	Y N P
Tuberculosis:	Y N P	Asthma:	Y N P
Bronchitis:	Y N P	Painful breathing:	Y N P

Shortness of breath with exertion: Y N P
Shortness of breath with siting: Y N P
Shortness of breath with lying down: Y N P

Cardiovascular

High blood pressure	Y N P	Arrythmias:	Y N P
Low blood pressure	Y N P	Palpitations:	Y N P
Rheumatic fever	Y N P	Edema:	Y N P
Murmurs	Y N P	Chest pain:	Y N P

Gastrointestinal:

Bowel movement frequency: _____________		Ulcer	Y N P
Recent change in BM	Y N P	Diarrhea	Y N P
Heartburn	Y N P	Constipation	Y N P
Indigestion	Y N P	Pancreatitis	Y N P
Bloating	Y N P	Liver disease	Y N P
Nausea	Y N P	Hemorrhoids	Y N P
Vomiting	Y N P	Gallbladder disease	Y N P

Date of last colonoscopy: ________________

Pelvic Organs/Urinary

Sexually active	Y N P	Hernia	Y N P
Contraception: ________________________		Color of urine ____________________	
Healthy Libido	Y N P	Testicular pain	Y N P
STI/STD	Y N P	Testicular bumps/swelling	Y N P
Painful intercourse	Y N P	Self-testicular exam	Y N P
Discharge	Y N P	Difficulty getting erection	Y N P
Incontinence	Y N P	Difficulty keeping erection	Y N P
Pain with urination	Y N P	Abnormal PSA	Y N P
Frequent urinary infection	Y N P	Digital rectal exam	Y N P
Kidney stones	Y N P	Prostate cancer	Y N P
Urgency	Y N P	Prostate swelling	Y N P
Blood in urine	Y N P	Prostate surgery	Y N P

Gynecology

Self-breast exams	Y N P	Age periods began: _____________________	
Breast implants	Y N P	# of pregnancies and births: _____________	
Mammogram	Y N P	Date: ______________ Abnormal? _____________	
Infertility	Y N P	1st day of last menses ____________________	
Use of hormones	Y N P	Frequency and length ____________________	
Vaginitis	Y N P	PMS symptoms	Y N P
Vaginal dryness	Y N P	Heavy bleeding	Y N P
Last pap date: _________________		Severe cramping	Y N P
Abnormal paps?	Y N P	Age entered menopause ____________or N/A	

Musculoskeletal:

Neck pain	Y N P	Arthritis	Y N P
Neck stiffness	Y N P	Tremors	Y N P
Weakness	Y N P	Leg cramps	Y N P
Morning stiffness	Y N P	Fractures	Y N P
Joint pain	Y N P	Joint fusions	Y N P
Muscle pain	Y N P	Joint swelling	Y N P
DEXA/Bone Scan:	Y N P	Date: _____________ Abnormal? _____________	

Nervous:

Burning/tingling	Y N P	Difficulty swallowing	Y N P
Seizures	Y N P	Paralysis	Y N P
Fainting	Y N P	Vertigo/Dizziness	Y N P
Blacking out	Y N P	Falling	Y N P
Difficulty speaking	Y N P	New headache	Y N

Skin

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

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

Endocrine

Hair loss	Y N P	Excess hunger	Y N P
Cold intolerance	Y N P	Excess thirst	Y N P
Dizzy when standing up	Y N P	Excess urination	Y N P

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		

Describe your:

Focus/Concentration ____

Memory/Recall ____

Comprehension ____