

Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures
Asthma Allergies Other (explain below)

Occupation _____ Occupational Stress (chemical, physical, psychological, etc.) _____

Do you have a regular exercise program? _____ Please describe: _____

Have you ever been on a restricted diet? _____ What kind? _____

Please describe your average diet. (Please be as specific as possible.)

Morning Meal Afternoon Meal Evening Meal Snacks

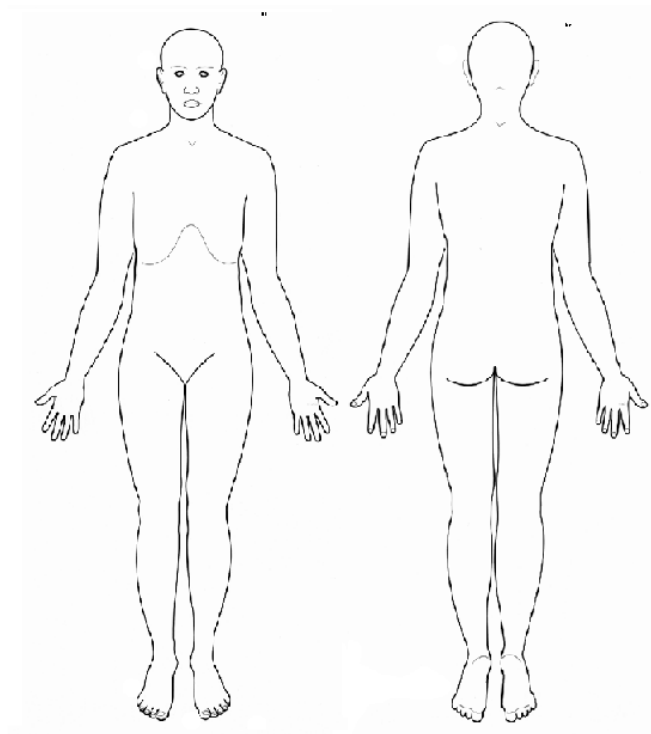
Do you smoke? _____ If so, how many per day? _____

How many drinks of coffee, tea, or soft drinks do you drink on average per week? _____

How much alcohol do you drink on average per week? _____

Please describe any use of drugs for non-medicinal purposes. _____

Please indicate painful or affected areas on charts below.



Please check if you have had any of the following symptoms in the last three months:

General:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Strong thirst (cold or hot drinks) | <input type="checkbox"/> Sudden energy drop |
| | | Time of day? _____ |

Explain: _____

Skin and Hair:

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | | |

Any other hair or skin issues to discuss? _____

Head, Eyes, Ears, Nose, and Throat:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Jaw clicks | |

Headaches (where and when?) _____

Any other head or neck issues to discuss? _____

Cardiovascular:

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in breathing |

Any other heart or blood vessel issues to discuss? _____

Respiratory:

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Production of phlegm. What color? _____ | |

Any other breathing or respiratory issues to discuss? _____

Gastrointestinal:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic laxative use | |

Any other issues with your stomach or intestines? _____

Genito-Urinary:

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |

Do you wake up to urinate? _____ If so, how often? _____

Is there any particular color to your urine? _____

Any other issues with your genital or urinary system? _____

Pregnancy and Gynecology (women only):

- | | | |
|---|--|--|
| ___ Number of Pregnancies | ___ Number of births | ___ Premature births |
| ___ Miscarriages | ___ Abortions | ___ Age at first menses |
| ___ Period between menses | ___ Duration | ___ First date of last menses |
| ___ Last PAP | <input type="checkbox"/> Heavy or light menses | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast tenderness |
| <input type="checkbox"/> Changes in body or emotional prior to menstruation | | |

Do you practice birth control? _____ If so, what kind and for how long? _____

Musculoskeletal:

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip pain |

Do you experience joint pain? _____ If so, where? _____

Any other joint or bone issues? _____

Neuropsychological:

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Easily to anger | <input type="checkbox"/> Easily susceptible to stress | |

Have you ever been treated for emotional issues? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological issues? _____

Comments:

Please tell us any other issues you would like to discuss: _____
