

# PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (First, Middle, Last)

Reason for today's visit: \_\_\_\_\_

Onset of condition: \_\_\_\_\_ Methods tried to alleviate your condition: \_\_\_\_\_

Medications/Herbs/Vitamins/Supplements you take

Surgeries/accidents/hospitalizations/diseases with dates

Family History	Father	Mother	Siblings	Family History	Father	Mother	Siblings
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Females only: Are you pregnant?  No  Yes | Date of last menstrual period \_\_\_\_\_

## PLEASE CHECK YOUR PAST OR PRESENT SYMPTOMS

Musculoskeletal	Past	Now	Musculoskeletal/continued	Past	Now
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Sore/weak muscles	<input type="checkbox"/>	<input type="checkbox"/>
Head/neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain/clicking	<input type="checkbox"/>	<input type="checkbox"/>	<b>Nervous System</b>	<b>Past</b>	<b>Now</b>
Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
Arms/shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Elbows	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hands/wrists	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Hips	<input type="checkbox"/>	<input type="checkbox"/>	Light/sound sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell/taste	<input type="checkbox"/>	<input type="checkbox"/>
Knees	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>
Feet/Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Walking difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>

<b>Nervous system/continued</b>	<b>Past</b>	<b>Now</b>	<b>Eye/Ear/Nose &amp; Throat/cont.</b>	<b>Past</b>	<b>Now</b>
Irritability/tension	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>	Sore gums/tongue	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>	<b>Past</b>	<b>Now</b>	Throat problems	<input type="checkbox"/>	<input type="checkbox"/>
Irregular/fast heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Nasal problems	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>	<b>Past</b>	<b>Now</b>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Problems with urination	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/kidney/infections	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	<b>General</b>	<b>Past</b>	<b>Now</b>
<b>Gastrointestinal</b>	<b>Past</b>	<b>Now</b>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent colds/infections	<input type="checkbox"/>	<input type="checkbox"/>
Crave sweets	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Skin changes	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Lumps/lymph gland swelling	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>	<b>Female</b>	<b>Past</b>	<b>Now</b>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Irregular bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood stools	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>
Black stools	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Breast pain/lumps	<input type="checkbox"/>	<input type="checkbox"/>
Liver troubles	<input type="checkbox"/>	<input type="checkbox"/>	Genital pain	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>
Overweight	<input type="checkbox"/>	<input type="checkbox"/>	Problem pregnancies	<input type="checkbox"/>	<input type="checkbox"/>
Underweight	<input type="checkbox"/>	<input type="checkbox"/>	<b>Children</b>	<b>Past</b>	<b>Now</b>
<b>Eye/Ear/Nose &amp; Throat</b>	<b>Past</b>	<b>Now</b>	Learning difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Over activity	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Coordination problems	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	Food/medication sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Socially withdrawn	<input type="checkbox"/>	<input type="checkbox"/>
Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infection	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

If signed by someone other than the patient, please specify relationship to patient: \_\_\_\_\_

