PATIENT INFORMATION

Name: ____Date: _____________
(First, Middle, Last)

Reason for today's visit: ____

____

Onset of condition: __________ Methods tried to alleviate your condition: ____________________

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Medications/Herbs/Vitamins/Supplements you take

Surgeries/accidents/hospitalizations/diseases with dates

Family History	Father	Mother	Siblings	Family History	Father	Mother	Siblings
Cancer	☐	☐	☐	Hypoglycemia	☐	☐	☐
Diabetes	☐	☐	☐	Lung Disease	☐	☐	☐
Heart Disease	☐	☐	☐	Thyroid	☐	☐	☐
High Blood Pressure	☐	☐	☐	Other:	☐	☐	☐

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	☐	☐	Sore/weak muscles	☐	☐
Head/neck pain	☐	☐	Broken bones	☐	☐
Jaw pain/clicking	☐	☐	**Nervous System**	**Past**	**Now**
Pain between shoulders	☐	☐	Numbness/tingling	☐	☐
Arms/shoulders	☐	☐	Headaches	☐	☐
Elbows	☐	☐	Dizziness	☐	☐
Hands/wrists	☐	☐	Fatigue	☐	☐
Hips	☐	☐	Light/sound sensitivity	☐	☐
Legs	☐	☐	Loss of smell/taste	☐	☐
Knees	☐	☐	Cold hands and feet	☐	☐
Feet/Ankles	☐	☐	Confusion	☐	☐
Walking difficulty	☐	☐	Depression	☐	☐

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

_______________________________ _______________ _______________

Patient or Representative Signature Date Time

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