

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:  Single  Partner  Married  Separated  Divorced  Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit \_\_\_\_\_ Date began \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

What types of therapies have you tried for these problem(s) or to improve your health overall:

- Diet modification  Fasting  Vitamins/minerals  Herbs  Homeopathy  Chiropractic  Acupuncture  Conventional drugs  
 Other \_\_\_\_\_

Do you experience any of these general symptoms on a regular basis?

- Debilitating fatigue  Shortness of breath  Insomnia  Constipation  Chronic pain/inflammation  
 Depression  Panic attacks  Nausea  Fecal incontinence  Bleeding  
 Disinterest in sex  Headaches  Vomiting  Urinary incontinence  Discharge  
 Disinterest in eating  Dizziness  Diarrhea  Low grade fever  Itching/rash

Current medications (prescription or over-the-counter): \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): \_\_\_\_\_

Outcome: \_\_\_\_\_

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): \_\_\_\_\_

Do you consider yourself:  Underweight  Overweight  Healthy weight Your weight today: \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)? \_\_\_\_\_

What are your current health goals: \_\_\_\_\_

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive

- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Date of last GYN exam \_\_\_\_\_
- Mammogram + -
- PAP + -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_
- Surgical menopause
- Menopause

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:
  - Cigarettes: # /day \_\_\_\_\_
  - Cigars: # /day \_\_\_\_\_
- Alcohol:
  - Wine: # glasses/d or wk \_\_\_\_\_
  - Liquor: # ounces/d or wk \_\_\_\_\_
  - Beer: # glasses/d or wk \_\_\_\_\_
- Caffeine:
  - Coffee: # 6 oz cups/d \_\_\_\_\_
  - Tea: # 6 oz cups/d \_\_\_\_\_
  - Soda w/caffeine: # cans/d \_\_\_\_\_
  - Other sources \_\_\_\_\_
- Water: # glasses/d \_\_\_\_\_

## Exercise

- 5-7 days/wk
- 3-4 days/wk
- 1-2 days/wk
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk: #days/wk \_\_\_\_\_
- Run, jog, other aerobic - #days/wk \_\_\_\_\_

- Weight lift: #days/wk \_\_\_\_\_
- Stretch: #days/wk \_\_\_\_\_
- Other \_\_\_\_\_

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction

## Specific food restrictions:

- dairy  wheat  eggs
- soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Number of servings per day: \_\_\_\_\_
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip meals (which ones) \_\_\_\_\_
- \_\_\_\_\_
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

## Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals (describe) \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## I Would Like to:

### Energy, Vitality

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

### Body Composition

- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

### Stress: Mental and Emotional

- Learn how to reduce stress
- Think more clearly and be more focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

### Life Enrichment

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle