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Patient Medical History

Name: (Last, First, Middle) ____ Date: ____/____/_____

Marital Status: _______________ Children: (list ages) ____

Main problems / reasons for this appointment:
____
____
____

What treatments have you already had for these conditions and what was the result:
____
____
____

What was the diagnosis:
____

What alleviates the problem:
____

What makes the problem worse:
____

In general my symptoms are better in: __ AM __ Midday __ PM __ My symptoms do not change through out the day

Are your symptoms: __Improving __ Unchanged __ Getting worse

What is the level of your complaint? (circle) None – 0 1 2 3 4 5 6 7 8 9 10 - Agony

Additional concerns you would like addressed:
____

Allergies: Please list any drug or food allergies
____
____

Major Stress in the last six months:
____

Contagious Diseases / Significant Illnesses:

__ HIV/AIDS __ Hepatitis __ Herpes __ Autoimmune disease __ Cancer __ Diabetes __ Gallstones __ Thyroid disease

__ Venereal __ Drug Addiction __ Alcohol abuse __ Seizures

Major Surgeries: (Date / Description)
____
____

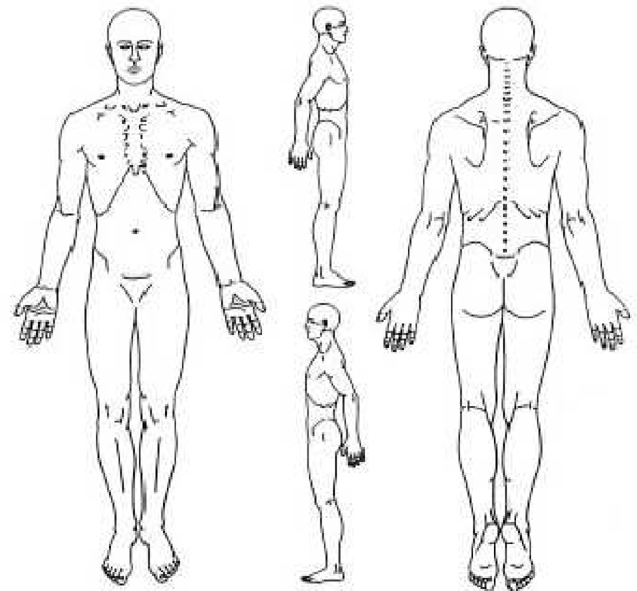
Major Traumas: (car accidents, falling, etc.)
____
____

Current Medications:	Dose:	Times/Day:
____	_____________	___________
____	_____________	___________
____	_____________	___________
____	_____________	___________
____	_____________	___________

Current Herbs, Vitamins and Supplements:	Dose:	Times/Day:
____	_____________	___________
____	_____________	___________
____	_____________	___________
____	_____________	___________
____	_____________	___________

Current Complaints: Place a circle on any area of pain or complaint and use the following symbols to describe what you are feeling.

A – Aching
S – Sharp / Stabbing
B – Burning
N – Numbness
T – Tingling / Pins and Needles
O - Other



Your Health Care Team

Family Physician: ____ Phone: (_____) ________________

Other Specialist: ____ Phone: (_____) ________________

Have you ever seen a:

Chiropractor: Yes / No Name: __________________________________

Acupuncture: Yes / No Name: __________________________________

Massage therapist: Yes / No Name: __________________________________

Health History

Please check any symptoms you currently have or have had in the past year.

Body Temperature

__ Warm natured __ Cold natured __ Cold hands and feet __ Flushed face __ Feel warmer at night __ Alternating chills/fever

__ Night sweats __ Hot flashes __ Profuse sweating __ Palm sweating __ Feet sweating __ Very little sweating

Thirst

__ Rarely thirsty __ Thirsty, but do not drink __ Always thirsty __ Prefer cold beverages __ Prefer hot beverages

Eyes

__ Cataract __ Tear easily __ Blurred vision __ Corrected vision __ Red/inflamed __ Spots in vision (floaters) __ Dry __ Itchy

__ Night Blindness __ Twitching __ Pain / strain

Ears

__ Earache __ Ear discharge __ Ringing (__ High pitch __ Low pitch) __ Hearing loss

Nose

__ Nasal obstruction __ Nasal discharge __ Nosebleeds __ Stuffy __ Sneeze __ Allergies __ Loss of sense of smell

Mouth and Throat

__ Phlegm in throat __ Feeling of lump in throat __ Swollen gums __ Hoarseness __ Recurrent sore throat __ Sores on lips

__ Sores on tongue __ Taste change __ Teeth problems __ Swollen glands __ Bitter taste

Head

__ Heaviness in the head __ Light headed __ Headache __ Migraines __ Sinus pressure __ Sinus pain

Respiratory

__ Asthma __ Hay fever __ Persistent cough __ Dry cough __ Coughing blood __ Shortness of breath __ Recurrent bronchitis

__ Cough with phlegm __ Difficulty inhaling __ Difficulty exhaling __ Tight chest

Cardiovascular

__ Chest pain __ High blood pressure __ Low blood pressure __ Irregular heart beat __ Palpitations __ Poor circulation

__ Swelling of ankles __ Varicose veins __ Hypochondriac pain __ Distention in chest __ High cholesterol

Gastrointestinal

__ Abdominal pain __ Bloating __ Gas __ Constipation __ Hard stools __ Diarrhea/loose stools __ Bloody stools __ Hemorrhoids

__ Laxative use __ Difficulty swallowing __ Poor appetite __ Heartburn/reflux __ Indigestion __ Belching __ Stomachache

__ Nausea / Vomiting __ Nervous stomach __ Motion sickness __ Vomiting blood __ Sighs frequently __ Hiccups __ Bitter taste

__ Bad breath

Diet/Lifestyle

__ Vegetarian __ Healthy diet __ Eat fried foods __ Eat red meat __ Use drugs __ Smoke cigarettes __ Drink alcohol (__ drinks/week)

__ Drink coffee (__ cups/day) __ Crave sweets __ Crave salts __ Take melatonin __ Take steroids __ Exercise regularly

__ Exercise excessively

Weight

__ Underweight __ Normal for height __ Overweight __ Very overweight __ Recent weight gain __ Recent weight loss

Urination

__ Dilute urine __ Dark urine __ Blood in urine __ Cloudy urine __ Burning urination __ Scanty urine __ Profuse urine

__ Frequent urination __ Poor bladder control __ Urgency to urinate __ Night urination __ Bladder infections

Musculoskeletal

Pain, weakness, numbness in: __ Arms __ Feet / Ankles __ Hands / Wrists __ Joints __ Legs __ Hips / Sciatic __ Neck __ Shoulders

__ Pain all over __ Cold limbs __ Pain in damp weather __ Knee problems __ Mid back pain __ Low back pain __ All over weakness

__ Broken bones __ Arthritis __ Muscle spasms

Skin / Hair / Nails

__ Broken blood vessels __ Blood not clotting __ Bruise easily __ Discoloration __Dark circles around eyes __ Dry skin __ Oily skin

__ Itchy skin __ Rashes / Eczema __ Acne __ Brittle nails __ Premature gray hair __ Dry, brittle hair __ Hair falling out

Neurological

__ Fainting __ Nervousness __ Convulsions __ Paralysis __ Stroke __ Seizures __ Tremor __ Recent clumsiness __ Drowsiness

__ Vertigo __ Dizziness __ Poor memory (__ Long term __ Short term)

Emotional / Sleep

__ Insomnia __ Hard to fall asleep __ Wakes frequently __ Troubling dreams __ Irritability __ Often feel angry __ Cry easily

__ Feel sad a lot __ Feels restless__ Forgetful __ Mind not clear __ Anxiety __ Much fear __ Unrestrained joy

__ Have difficulty making decisions __ Difficulty expressing emotions __ Fatigue / Low energy

Men Only

__ Genital pain __ Impotence __ Genital sores __ Lump in testicles __ Seminal emission __ Nocturnal emission __ Low sexual energy

__ Prostate problems

Women Only

___ Age of first period ___ Days between cycles ___ Days of flow

__ Abnormal pap smear __ Bleed between periods __ Irregular periods __ Painful periods __ Heavy periods __ Scanty periods

__ Clotting __ Blotting __ Breast tenderness __ Endometriosis __ Premenstrual tension __ Breast lumps

__ Contraceptives (Type _________________) __ Sores on genitalia __ Low sexual energy __ Vaginal discharges __ Yeast infections

__ May be pregnant __ Uterine prolapse __ Facial hair __ Loss of head hair

__ Menopause (__ Hot flashes __ Night sweats __ Emotional)