Main complaint:

Other complaints:

Dates of onset (first occurrence):

Pain: **O** Minimal **O** Moderate **O** Severe Where:
Rate the pain on a scale from 1 – 10.
Pain feels like: **O** Stabbing **O** Dull ache **O** Nagging **O** Like a tooth ache **O** Burning **O** Sharp
Have you had this in the past: **O** Yes **O** No When?
What makes it worse?
What makes it better?
Is your condition getting: **O** Worse **O** The Same **O** Comes and Goes O Better

Musculo-skeletal (muscle and joint pain):

Where	Pain	Weakness	Swelling	Stiffness

O Leg cramps **O** Muscle spasm **O** Loss of feeling/numbness Where:
O Tingling sensation
O Other:

Medications / drugs / herbs / supplements you are currently taking:

Allergies:

Date of your last physical examination: Outcome:

Height: Weight: Blood pressure:

Major surgeries + dates:

Fractures / Injuries/ Trauma/ Scars:

Medical history: (Do you have or have you ever had): **O** Arthritis **O** Asthma
O Anemia **O** Heart trouble **O** Cancer **O** Diabetes **O** Epilepsy **O** Stroke
O Kidney/ Bladder trouble **O** Gallstones **O** Ulcers **O** High blood pressure
O Chronic fatigue **O** Hepatitis **O** Jaundice **O** Sudden weight loss
O Sudden weight gain **O** Head injury **O** Chemical Dependency **O** Allergies
O Other:

Family history: Has any member of your direct family had any of the above? If yes, please clarify:
Father: Mother: Siblings:

Please mark signs and symptoms you have experienced in the last 3-6 months:

Energy level: **O** High (time of day) **O** Low (time of day)

Stress: **O** Low **O** Moderate **O** Severe What causes it?

Sweating: **O** Night sweats **O** Rarely sweat **O** Excess sweating

Circulation: Feelings of > **O** Hot **O** Cold What area?
O Bleed easily **O** Cold limbs **O** Other

Skin: **O** Dry **O** Itchy **O** Moist / Clammy **O** Burning **O** Changing moles /lumps **O** Discoloration
O Boils **O** Frequent skin rashes **O** Hives **O** Acne **O** Hair loss / thinning **O** Dry scalp
O Skin puffy / wrinkled **O** Bruises easily **O** Other:

Sleep: **O** Trouble falling asleep **O** Trouble staying asleep **O** Waking early **O** Restful
O Excess dreaming **O** Other problems? How many hours?

Head: **O** Headaches: Which part of the head?
O Dizzy **O** Memory loss **O** Loss of balance
O Other:

Eyes: **O** Eye pain **O** Dry eyes **O** Floaters **O** Blurry vision **O** Excess tearing
O Other:

Ears: **O** Poor hearing **O** Ringing / Buzzing **O** Earache **O** Discharge / infection
O Other:

Nose: **O** Nose bleeds **O** Sinus trouble **O** Frequent colds **O** Allergies **O** Other:

Throat: **O** Sore throat **O** Hoarseness **O** Difficulty swallowing **O** Jaw problems
O Teeth / gum problems **O** Mouth ulcers **O** Tongue ulcers
O Other:

Chest: **O** Hard to breathe **O** Wheezing **O** Short of breath **O** Persistent cough
O Trouble breathing at night **O** Pain / pressure in chest **O** Palpitations **O** Coughing blood
O Coughing phlegm Color of phlegm: Consistency: Other:
Tobacco: Packs a day: How many years:

Bowels: **O** Diarrhea **O** Constipation **O** Bloody stools **O** Black stools
O Hemorrhoids **O** Mucus in stools **O** Lower bowel gas **O** Foul smelling stools
O Colon problems Number of bowel movements /day: **O** Other:

Urine: Color: Amount: **O** Clear **O** Cloudy
Frequent urination: **O** Daytime **O** Night **O** Strong smelling **O** Pain or burning
O Hard to urinate **O** Dribbling **O** Stress incontinence **O** Frequent infections
O Water retention **O** Other:

Neurological:**O** Nervousness **O** Depressed **O** Easily angered **O** Easily irritated **O** Frequent crying **O** Worry / anxiety **O** Mood swings **O** Poor memory **O** Confusion **O** Poor concentration **O** Suicidal **O** Tremors **O** Poor coordination **O** Feeling weak / shaky **O** Seizures **O** Neuralgia **O** Shingles

Exercise:

Females: Pregnant **O** Yes **O** No Last period: Last PAP smear:
Birth control: **O** None **O** Pill **O** Other:
Age started menstrual cycle: Regular cycle: **O** Yes **O** No **O** Cycle length:
O Menstrual pain: **O** Before period **O** After period **O** During period **O** Low back pain
O Clotting **O** Heavy bleeding **O** Light scanty bleeding Color:
O Water retention **O** Mood changes **O** Missed periods **O** Low or no sex drive
O Painful breasts **O** Hot flushes **O** Food cravings **O** Other:
Vaginal discharge: **O** Yellow **O** White **O** Thick **O** Watery **O** Odor **O** Itching
Number pregnancies: Number deliveries: Number miscarriages:
Number cesareans: Operations: **O** Cervix **O** Uterus **O** Ovaries
Other: **O** Fibroids **O** Endometriosis

Males: **O** Low sex drive **O** Lack of sex drive **O** Impotence **O** Pain with ejaculation **O** Discharges
O Pain or burning with urination **O** Premature ejaculation **O** Prostate issues **O** Other:

Appetite: **O** Excessive **O** Poor appetite **O** Appetite changes **O** Feel weak or tired if a meal is missed **O** Food cravings What:
Preference for hot or cold meals:

Thirst: **O** Excess **O** Never thirsty
Preference for hot or cold drinks:

Digestion: **O** Stomach gas **O** Lower bowel gas **O** Heart burn **O** Churning
O Belching **O** Stomach pain **O** Stomach cramps **O** Nausea **O** Vomiting
O Bad breath **O** Sores in mouth **O** Weight gain **O** Weight loss
Taste in mouth: **O** Bitter **O** Sour **O** Sweet **O** Sticky **O** Metallic
O Abnormal bloating How long after eating?
O Food allergies If yes which foods?

O Other:

Nutrition: List some of your favorite foods:

Do you: **O** Skip breakfast **O** Eat snacks **O** Eat a hearty breakfast
How many meals a day? When is your biggest meal?
Do you eat when you are worried or upset?
How many glasses of water do you drink a day? **O** Bottled **O** Filtered
DO YOU:
Eat raw fruits or vegetables at least x2 / day?
Eat meat or dairy products 2 or more times a day?
Eat frequently between meals? Eat when you are not hungry?
Chew your food thoroughly? Eat when you feel full?
Occasionally go on a crash diet?
Do you drink: **O** Milk **O** Juice **O** Sodas **O** Diet sodas **O** Alcohol **O** Social **O** Daily How many?
O Black tea How many cups / day? **O** Coffee How many cups / day?

Comments:

Patient Signature: **Date**: