



**MEDICAL SUPERVISION** (please list your physicians and all other healthcare professionals along with their phone numbers. Put a check next to those whom you give me permission to contact about your diagnoses, your health history, past medical tests, scans, evaluations and reports):

**CHIEF COMPLAINT(S)** (Why have you come to see me):

**HOW LONG HAVE YOU HAD THESE SYMPTOMS/CONDITIONS:**

**WHAT HAVE YOU OR YOUR PHYSICIANS OR ANY HEALTHCARE PROVIDERS DONE UP TO NOW TO TREAT YOUR CHIEF COMPLAINT(S). ALSO, PLEASE TELL ME WHAT HAS HELPED:**

**MEDICATIONS** (Please list your medications and the reasons for taking them. Make sure that you provide the doses and proper spelling for each medication):

**VITAMINS, MINERALS, HERBS AD OTHER NUTRIENT SUPPLEMENTS** (Be precise about spelling and doses):

**HOSPITALIZATIONS** ( if you can, please list dates, hospitals, and reasons):

**PERSONAL MEDICAL HISTORY** (check all those applicable to you):  measles  mumps  rubella  polio  
 hepatitis A/B/C (circle the correct choice)  whooping cough  tuberculosis  rheumatic fever  mononucleosis  
 chicken pox  thyroid disease  seizures (the diagnosis was: \_\_\_\_\_)  high blood pressure  
 ear infections  herpes  epilepsy  eczema  cancer (the diagnosis was: \_\_\_\_\_ )  
 diabetes type I/II (circle)  thyroid disease  asthma  heart disease (the diagnosis was: \_\_\_\_\_ )  
 alcoholism  osteoarthritis  rheumatoid arthritis  any gastrointestinal condition (which: \_\_\_\_\_ )  
others (list any other chronic illnesses, infectious illnesses, emotional conditions, or injuries): \_\_\_\_\_

**FAMILY MEDICAL HISTORY (please tell me if there is a family history of any of the following):**

- thyroid disease  seizures (the diagnosis was: \_\_\_\_\_)
- high blood pressure  arthritis  depression  ulcers  anemia
- sickle cell anemia  anxiety  allergies  cancer (the diagnosis was: \_\_\_\_\_)
- alcoholism  diabetes type I/II (circle)  thyroid disease  colitis  irritable bowel
- other gastrointestinal conditions(list other conditions: \_\_\_\_\_)
- asthma  heart disease (the diagnosis was: \_\_\_\_\_)
- others (list any others): \_\_\_\_\_

**LIFESTYLE:**

DO YOU EXERCISE REGULARLY: IF SO, TELL ME WHAT YOU DO AND HOW MUCH TIME YOU SPEND DOING IT:

RATE YOUR CURRENT LEVEL OF STRESS ON A SCALE OF 1-10 (1 = NO STRESS 10= TREMENDOUS STRESS):

WHAT ARE THE GREATEST SOURCES OF STRESS IN YOUR LIFE?:

DO YOU HAVE ANY KIND OF STRESS REDUCTION PRACTICE?:

IF SO, WHAT IS IT:

ON THE AVERAGE, DESCRIBE YOUR ENERGY LEVEL ON A SCALE FROM 1-10 (#1 representing "worst" and #10 representing "best"):

HOW IS YOUR BODY TEMPERATURE IN COMPARISON TO OTHERS (COOLER, WARMER, NO DIFFERENT)?

HOW IS THE TEMPERATURE OF YOUR HANDS AND FEET (USUALLY COLD, WARM, AVERAGE)?

DO YOU ENJOY YOUR WORK? HOW MANY HOURS DO YOU WORK PER WEEK ON THE AVERAGE?

DO YOU HAVE PEOPLE WHO SUPPORT YOU?

DO YOU EVERY SWEAT AT NIGHT? IF YOU DO, IS THIS A FREQUENT OCCURRENCE?

HOW MANY HOURS DO YOU SLEEP ON THE AVERAGE?

WHAT TIME DO YOU GENERALLY GO TO SLEEP DURING THE WEEK? ON WEEKENDS?

DO YOU AWAKEN FEELING REFRESHED?

DO YOU AWAKEN DURING THE NIGHT? IF SO, HOW OFTEN?

IF YOU AWAKEN DURING THE NIGHT, WHY DO YOU DO SO?

ARE YOU A VEGAN? A VEGETARIAN? IF SO, FOR HOW LONG?

WHAT BRINGS YOU JOY, FUN, OR PLEASURE?

SHARE SOME OF YOUR CHILDHOOD, ADOLESCENT AND ADULT ACCOMPLISHMENTS:

**CURRENT MEDICAL STATUS AND SYMPTOMS (Simply check the items that apply):**

GENERAL:

- More than 3 colds per year  Need for a lot of sleep  Interrupted sleep  Persistent insomnia  Persistent swelling of ankles or excessive fluid retention  Persistent bad breath  Persistent body odor  Easily bruised  Slow to heal wounds  Ridged nails  Spots under nails

Nails that break easily or split easily  White spots or speckles on nails  Cannot remember dreams  Consistent exposure to car fumes, chemical exposure, second-hand smoke, chemical pollutants, environmental pollutants, toxins,  Little daily exposure to light  Little daily exposure to fresh air  Stressful job/personal life  Chronic swelling in lower legs  Varicose veins  White "moons" on nails that cover more than ¼ of those nails  Burning sensation in hands or feet  Poor appetite  Strong thirst  Poor balance  Dizziness  Light-headedness

#### SKIN AND HAIR:

Rashes  Itching scalp  Dandruff  Flaking skin  Ulcerations  Hives  Eczema  Oily skin with enlarged pores  "Chicken skin" at the back of arms and elbows  Dry skin at elbows  Hair loss  Dull hair  Any skin markings or blemishes that have changed shape or color or have grown in size  Thinning hair  Any other conditions of skin or hair you wish to mention?

#### HEAD, EYES, EARS, NOSE, THROAT:

Poor vision  Floaters  Cataracts  Blurry vision  Poor night vision  Color blindness  
 Eye pain  Ringing in ears (tinnitus)  Sinus problems  Black circles under eyes  Edema around eyes (puffy eyes)  
 Red blood vessels in your eye(s)  Grinding teeth  Bleeding gums  Mouth ulcers  Canker sores  Poor hearing  Cold sores  
 Recurrent sore throats  Headaches  Migraines  Nose bleeds  Ear aches  Jaw clicks  Jaw pain  Persistent nasal congestion  Persistent runny nose  Red earlobes/burning earlobes (especially after eating)  Cracks at the corners of your mouth or nose  Poor sense of taste  Poor sense of smell  Cracks and /or grooves on tongue  Visible "scaloped" indentations around the sides of the tongue  Persistent white coat on tongue  Excess earwax  Frequent nosebleeds  Visible veins around nose  Skin tags on the front or sides of your neck  
Any other conditions you wish to mention?

#### CARDIOVASCULAR:

Cold hands and feet  Irregular heartbeat  Blood clots  Low blood pressure  High blood pressure  Swelling of hands  Swelling of feet  Difficulty breathing  Chest pain  Fainting  Phlebitis  Any other conditions of the cardiovascular system you want to mention:

#### RESPIRATORY:

Cough (If yes, is your cough:  dry and unproductive  tinged with blood  accompanied by phlegm and/or mucus -- if so, what color phlegm or mucus: \_\_\_\_\_  Asthma  Pneumonia  Difficulty inhaling or breathing  Weak voice  Tight chest  
 Pain with deep inhalation  Any other respiratory conditions or symptoms to mention?

#### GASTROINTESTINAL:

Gas or indigestion immediately after a meal  Gas or indigestion several hours after a meal  Feeling of food stomach for several hours after meals  Gas or digestive problems after consuming dairy  Gas or digestive problems after eating raw foods  Digestive problems after rich, fatty meals  Indigestion or bloating around the stomach region  Indigestion or bloating below the navel  
My stool is:  loose  well-formed  brown to dark brown  light brown to yellowish brown  sinks  floats  contains pieces of food  
 I feel nauseous often  Constipation  Black stools  Bad breath  Abdominal cramps  Vomiting  Rectal pain, burning, or itching  
 Belching  Hemorrhoids  Chronic laxative use  Any other g.i. symptoms you wish to mention?

#### GENITO-URINARY:

Pain on urination  Burning sensation on urination Is your urine:  scanty  copious  strong odor  Difficulty stopping or starting when

urinating  Blood in urine  Awaken to urinate at night  Urgent need to urinate  Kidney stones  Impotence

Any other genito-urinary conditions you wish to mention?

**REPRODUCTIVE AND GYNECOLOGIC:**

Menstrual clots  Painful menses  Unusual menses:  Heavy menses  Light menses  Irregular menses  Period begins every  
 days...Periods last \_\_\_ days  Spotting or bleeding between periods  Yearly PAP smears  Abnormal PAP smears  Breast lumps

Fibroids  Uterine abnormalities: What are they? \_\_\_\_\_

Menopause: At what age? \_\_\_\_\_  Premenstrual symptoms: What? \_\_\_\_\_

Age at first menses: \_\_\_ Number of pregnancies: \_\_\_ Number of premature births: \_\_\_ Number of abortions: \_\_\_

Number of miscarriages: \_\_\_ Birth control: If so, which medication or what kind of birth control \_\_\_\_\_

**MUSCULOSKELETAL:**

Neck pain  Leg cramps during sleep or at night  Back pain  Hand/wrist pain  Muscle pains  Muscle weakness

Difficulty keeping or building muscle  Shoulder pain  Knee pain  Foot/ankle pain  Hip pain  Bone loss  Brittle bones

Joint pain: Where? \_\_\_\_\_ Any other joint, muscle, or bone problem you wish to mention? \_\_\_\_\_

**NEUROPSYCHOLOGICAL:**

Seizures  Areas of numbness: Where? \_\_\_\_\_  Concussion  Poor memory  Depression  Anxiety  Susceptible to stress

Any other emotions or neurological symptoms you wish to discuss?

**1. Check those items which apply to you:**

Are you exposed to chemical or environmental toxins at work or home:

If so, to what have you been exposed:

**2. Describe an average daily diet (please include all kinds of foods beverages and be as complete as possible):**

First thing when I get up, I might have:

For breakfast, I might have:

For a mid-morning snack, I might have:

For lunch, I might have:

For a late-afternoon snack, I might have:

For dinner, I might have:

For an evening snack, I might have:

In the middle of the night, I might have:

3. List any exercise, including tai chi or yoga or pilates or qigong, you do during an average week:

**PLEASE USE THIS SPACE TO TELL ME ANYTHING ELSE YOU CONSIDER TO BE IMPORTANT FOR ME TO KNOW. PLEASE CONSIDER THIS FOR A MOMENT. ANY INFORMATION YOU MIGHT PROVIDE CAN GIVE ME INSIGHT INTO YOUR RECOVERY:**

Please print and sign your name and record the date where indicated below if you agree that the information you have provided in this form is true.

Print your name: \_\_\_\_\_

Sign your name: \_\_\_\_\_ Record the date: \_\_\_\_\_

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