

Name: Last _____ First _____ Middle Initial _____

PRIMARY HEALTH CONCERNS

Please list your main health concerns from most to least important:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

HEALTHCARE

Are you currently seeing a healthcare practitioner? Y___ N___

If yes, please list your current providers (complementary/alternative and conventional). Please list type of provider. *(Your provider will not be contacted without a signed release form authorizing communication between providers.)*

Are you currently working with a psychiatrist, professional counselor, social worker, case manager, psychologist, psychotherapist, psychoanalyst (Jungian, Freudian), pastor, priest, rabbi or other therapist?

Y___N___(Please circle all that apply)

Have you worked with any of these professionals in the past? Y___ N___

If yes, who (I will not contact them without your consent) and when? _____

If no, when and where did you last seek medical care? _____

(I would request your permission in writing before I would contact these providers on your behalf.)

What modalities or therapeutics have you typically responded well to?

Are there any modalities or therapeutics that you have experienced an adverse response to, or are opposed to trying? (please specify reason)

If you have been treated with homeopathy in the past, please list any remedies that you took (including potency and frequency) as well as their effect: _____

Name: Last _____ First _____ Middle Initial _____

GENERAL INFORMATION

Height: _____ feet _____ inches Weight (lb): _____ Weight one year ago (lb): _____

Maximum (non-pregnant) weight (lb): _____ When? _____

Are you happy with your current weight? Y ___ N ___

Energy level: (circle most appropriate 1-2 that represents your state most of the time)

poor - up and down- good, steady- strong- excessive

What time of day do you tend to feel best? _____ and worst? _____

HEALTH HABITS

Exercise: Type(s) _____

_____ Frequency _____

Sleep: Average number of hours per night _____ Awake feeling rested? Y ___ N ___

Difficulty falling asleep? Y ___ N ___ Wake early and can't get back to sleep? Y ___ N ___

Dreams that you recall? Y ___ (please circle) *nightly weekly monthly other* N ___

Nightmares? Y ___ N ___ Recurrent dreams? Y ___ N ___ *If yes, please describe:*

Eating & Drinking: *Please describe a typical day's food & drink.*

Breakfast _____

Lunch _____

Dinner _____

Snacks (please note time(s)) _____

Fluids _____

How many meals do you typically have each day? ___ What time(s)? ___ / ___ / ___

What foods do you crave? _____

What foods do you dislike? _____

What foods do you react poorly to or have an allergy to? _____

How many glasses of water do you drink a day? _____

How often do you eat out? _____ What kinds of food? _____

Do you or someone else in your household do most of the cooking? _____

Name: Last _____ First _____ Middle Initial _____

HEALTH HABITS~2~

Have you ever gone on a diet? Y__ N__ If so which kind? _____

Drink coffee: Y__ N__ Quantity _____ Frequency _____ Type _____

Drink soda: Y__ N__ Quantity _____ Frequency _____ Type(s) _____

Substance use:

Drink alcohol: Y__ N__ Quantity _____ Frequency _____ Type(s) _____

Smoke cigarettes/chew tobacco: Y__ N__ Quantity _____ Frequency _____ Since _____

History of smoking? Y__ N__ If yes, #of years: _____ # of packs per day: _____

Do you currently suffer from a substance abuse or an eating disorder? Y__ N__

Please specify which one(s): _____

Have you had or ever been treated for:

Alcoholism? Y__ N__ If yes, when? _____ Involved with AA? Y__ N__

Eating disorder? Y__ N__ If yes, when? _____ Type _____

Drug dependence? Y__ N__ If yes, when? _____ Drug(s)used _____

Do you use drugs recreationally? Y__ N__ If yes, which one(s)? _____

_____ & how often? _____

Work, Study & Recreation:

Do you enjoy your work &/studies? _____

Do you read for pleasure? Y__ N__ What genre(s)? _____

Do you watch television? Y__ N__ If yes, number of hours per day? (average) _____

Favorite show(s) _____

What type of movies do you enjoy? _____

What do you enjoy doing/consider a hobby? _____

Do you take vacations? Y__ N__ If yes, where? _____ how often? _____

Do you have a spiritual/religious practice? Y__ N__ If yes, what? _____

How is your stress level? (*please circle*) low moderate high

What are your major stressors? _____

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LIFESTYLE
Please describe a typical day (<i>times rising, eating, types and duration of activities, etc.</i>): Workday _____ _____
Non-work day _____ _____
How many hours per day do you spend in a car/bus/lightrail train? _____
Please describe any treatments you currently follow or engage in (not including medication, supplements or other ingested treatments) <i>i.e. meditation, hydrotherapy, massage/bodywork, journaling, active imagination, etc.</i> _____ _____
Have you recently made any significant lifestyle changes? Y__ N__ If yes, please describe: _____ _____

LIFE SATISFACTION
In order to get a sense of where you are in beginning treatment, your assessment of the following areas will be helpful in guiding treatment.
Health <i>dissatisfied/stressed</i> <i>mostly satisfied</i> <i>very satisfied</i>
Career <i>dissatisfied/stressed</i> <i>mostly satisfied</i> <i>very satisfied</i>
Relationships (Friends, family, significant other) <i>dissatisfied/stressed</i> <i>mostly satisfied</i> <i>very satisfied</i>
Recreation (includes time available for, ability to engage in the activities, etc.) <i>dissatisfied/stressed</i> <i>mostly satisfied</i> <i>very satisfied</i>
Financial Status <i>dissatisfied/stressed</i> <i>mostly satisfied</i> <i>very satisfied</i>
Physical Environment <i>dissatisfied/stressed</i> <i>mostly satisfied</i> <i>very satisfied</i>
If further comment or explanation is necessary, please use the space below:

Name: Last _____ First _____ Middle Initial _____

FAMILY

Marital status (please circle current status)

Single Partnered* Married* Widowed Divorced

*Partner or spouse's name _____ *Partner/spouse's occupation _____

Children/Stepchildren? Names & ages: _____

Pets (please list all by type of animal/bird/creature): _____

Is your mother living? Yes, age: _____ Current health status: _____

N, age when died _____ Cause of death: _____

Is your father living? Yes, age: _____ Current health status: _____

N, age when died _____ Cause of death: _____

Do you have siblings? Yes, age(s): _____ Current health status: _____

N, age when died _____ Cause of death: _____

Do you have a family history of any of the following? (Please include parents, brothers, sisters, stepbrothers and stepsisters (if blood relatives) and grandparents.)

- Alcoholism/Chemical dependency
- Allergies
- Alzheimer's disease
- Anemia
- Arthritis, gout
- Asthma
- Autoimmune condition *If yes please list specific condition(s):* _____
- Bleeding disorder *If yes please list specific condition(s):* _____
- Cancer? Type _____
- Cataracts
- Celiac disease
- Diabetes
- Eczema
- Gallbladder disease
- Gonorrhea
- Headaches/migraines
- Hearing loss
- Heart disease
- High blood pressure
- Hypoglycemia
- Kidney disease
- Liver disease
- Osteoporosis
- Parkinson's disease
- Seizures
- Stroke
- Suicide
- Syphilis
- Thyroid condition
- Tuberculosis
- Ulcers
- Other _____
- Mental health condition? If yes:
 - Anxiety
 - Depression (unipolar)
 - Bipolar
 - Schizophrenia

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MEDICAL HISTORY

Please check the following if you have experienced the condition **within the past 6 months** or circle if you have experienced it in the past **over 6 months ago**. Please also indicate if there is one **side** that the condition predominates (“L” for left, “R” for right).

General

- ___ Significant weight gain
- ___ Significant weight loss
- ___ Weight stable
- ___ Weakness
- ___ Fatigue (excessive)
- ___ Intolerance to cold
- ___ Intolerance to heat
- ___ Excessive thirst
- ___ Excessive sweating
- ___ Night sweats

Allergies

- ___ Foods
- ___ Food additives
- ___ Cosmetics
- ___ Inhalants
- ___ Aspirin
- ___ Insect bites
- ___ Other medications
- ___ Other _____

Skin

- ___ Heals slowly
- ___ Bruises easily
- ___ Dry
- ___ Oily
- ___ Acne
- ___ Boils
- ___ Colour changes
- ___ Hives
- ___ Itchiness
- ___ Psoriasis
- ___ Eczema
- ___ Other rashes
- ___ Athlete’s foot

Skin

- ___ Moles
- ___ Changes to moles
- ___ Spider/varicose veins
- ___ Nail fungus
- ___ Nail ridges
- ___ Bumps on skin on back of arms
- ___ Lumps

Head/neck

- ___ Headaches
- ___ Migraines
 - Dull
 - Sharp
 - Stabbing
 - Pressure
- Band around head
- Frequency _____/month
- Duration _____ hours

Location:

- Neck
- Temple(s)
- Forehead
- Back of head
- Eyes (around, behind)
- Jaw
- Diffuse (i.e. all over head)

- ___ Dizziness
- ___ Vertigo
- ___ Head Injury
- ___ Hair loss (excessive)
- ___ Jaw pain/TMJ
- ___ Swollen glands
- ___ Goiter
- ___ Neck Injury

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MEDICAL HISTORY ~2~

EYES

- ___ Blurriness
- ___ Cataracts
- ___ Double vision
- ___ Itchiness
- ___ Redness
- ___ Watery Eyes
- ___ Dry Eyes
- ___ Eye pain/strain
- ___ Discharge from eyes
- ___ Floaters/Halos/flashes
- ___ Glaucoma
- ___ Glasses/contacts
 - Astigmatism
 - Near-sighted
 - Far-sighted
- ___ Laser surgery
- ___ Colour blindness
- ___ Poor night vision
- ___ Vision loss
- ___ Inflamed lids
- ___ Styes
- ___ Infection
- ___ Injury

EARS

- ___ Ear aches
- ___ Excessive wax
- ___ Ringing in ears
- ___ Oversensitive to noise
- ___ Hearing loss
- ___ Infections

NOSE & SINUSES

- ___ Post-nasal drip
- ___ Hay fever
- ___ Nosebleeds
- ___ Congestion
- ___ Sinus infection/pain
- ___ Loss of smell

MOUTH & THROAT

- ___ Dry throat
- ___ Copious saliva
- ___ Lump in throat
- ___ Canker sores
- ___ Sores on corner(s) of mouth
- ___ Loss of taste
- ___ Metallic taste
- ___ Sour taste
- ___ Bad breath
- ___ Hoarseness
- ___ Difficulty swallowing
- ___ Grinding teeth
- ___ Jaw pain/clicking
- ___ Sore throat
- ___ Snoring

TEETH

- Date of last dental exam: _____
- ___ Toothaches
 - ___ Sensitive to cold
 - ___ Root Canal
 - ___ Implants
 - ___ Braces/Retainer
 - ___ Dentures
 - ___ Amalgams: Type _____ Number _____

GUMS

- ___ Bleeding
- ___ Sore
- ___ Receding
- ___ Infected

TONGUE

- ___ Sore
- ___ Swollen
- ___ Inflamed
- ___ Split
- Coat: White
- Yellow
- Other _____

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MEDICAL HISTORY ~3~

RESPIRATORY

- ___ Shortness of breath
- ___ Chest pain on exertion
- ___ Wheezing
- ___ Cough
- ___ Pain with breathing
- ___ Coughing up blood
- ___ Green or yellow sputum
- ___ Asthma
- ___ Bronchitis
- ___ Pneumonia
- ___ Emphysema
- ___ Tuberculosis

CARDIOVASCULAR

- ___ High blood pressure
- ___ Low blood pressure
- ___ High cholesterol
- ___ Chest pain
- ___ Angina
- ___ Heart disease
- ___ Heart attack
- ___ Heart murmur
- ___ Irregular pulse
- ___ Rapid pulse

- ___ Arrhythmia
- ___ Palpitation
- ___ Faintness/dizziness on rising
- ___ Varicose veins
- ___ Spider veins
- ___ Swelling in ankles
- ___ Blood clots
- ___ Fainting
- ___ Anemia

PERIPHERAL VASCULAR

- ___ Cold hands
- ___ Cold feet
- ___ Deep leg pain

GASTROINTESTINAL

- ___ Abdominal pain/cramps
- ___ Bloating
- ___ Belching
- ___ Heartburn
- ___ Ulcers
- ___ Indigestion
- ___ Nausea
- ___ Vomiting
- ___ Gallbladder disease
- ___ Liver disease
- ___ Excessive appetite
- ___ Poor appetite
- ___ Flatulence
- ___ Constipation
- ___ Diarrhea
- ___ Hemorrhoids
- ___ Itching around anus
- ___ Pain on passing stool
- ___ Rectal spasm

- Stool:
- ___ Black
- ___ Yellow
- ___ Brown
- ___ Bloody

- ___ Mucus
- ___ Thin
- ___ Frothy
- ___ Undigested food in
- ___ Unformed/loose
- ___ Formed
- ___ Hard little pellets
- ___ # of bowel movements per day

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MEDICAL HISTORY ~3~

URINARY

- ___ Pain with urination
- ___ Burning with urination
- ___ Urgency
- ___ Difficulty starting urination
- ___ Difficulty holding urine
- ___ Urination with cough or sneeze
- ___ Kidney or bladder infection
- ___ Frequent infections
- ___ Splitting of stream
- ___ Kidney stones
- ___ Blood in urine
- ___ Dark yellow urine
- ___ Yellow urine
- ___ Clear urine
- ___ Cloudy urine
- Frequency ___ # times/day
- ___ # times/night

FEMALE

- Age of 1st menses ___
- Age of last menses (if menopausal) _____
- Menstrual cycle:
Duration of bleeding _____
- Length of cycle* _____
- ___ Bleeding between periods
- ___ Clotting
- ___ Menstrual cramps, painful periods
- ___ Irregular periods
- Flow *heavy / medium / light*
- # pads/tampons on heaviest day:

- ___ PMS: symptoms: _____
- _____
- ___ Cervical dysplasia
- ___ Previously abnormal PAP smear
- ___ Date of last PAP smear _____
- ___ Endometriosis
- ___ Infection
- ___ Ovarian cysts

FEMALE

- ___ Breast lump(s)
- ___ Breasts tender
- ___ Nipple discharge
- ___ Do breast self-exam (monthly)
- ___ Mammograms (regular)
- ___ Abnormal mammogram
- ___ Breast implants
- ___ Breast fe(e)d child(ren)
- ___ Decreased libido
- ___ Sexual difficulty/pain
- Sexual orientation _____
- ___ Sexually active currently
- ___ Sexually active in past
- Type of birth control (if applicable):
Current: _____
- Past:* _____
- Adverse reactions to?* _____
- Use of hormone replacement _____
- Menopausal symptoms
- ___ vaginal dryness
- ___ hot flashes
- ___ changes in mood
- ___ other: _____
- _____
- Currently pregnant? ___ # of months _____
- Difficulty conceiving? _____
- # of pregnancies: _____
- # of live births: _____
- # of miscarriages: _____
- # of abortions: _____
- Date of last STD/STI testing? _____
- ___ Discharges or sores
- ___ Genital herpes
- ___ Condyloma/genital warts
- ___ Gonorrhea
- ___ Chlamydia
- ___ Syphilis
- ___ Other STD/STI: _____

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MEDICAL HISTORY ~4~

MALE

- Date of last physical exam: _____
- ___ Hernias
- ___ Erectile dysfunction
- ___ Premature ejaculation
- ___ Painful ejaculation
- ___ Testicular pain
- ___ Testicular mass(es)
- ___ Testicular self-exam (monthly)
- ___ Penile discharge
- ___ Benign Prostatic Hypertrophy
- ___ Prostatitis
- ___ Ever had prostate exam?
- ___ Ever had PSA level checked?
- ___ Abnormal PSA level
- ___ Pain or swelling in groin
- Sexual orientation _____
- ___ Sexually active currently
- ___ Sexually active in past
- ___ Decreased libido
- ___ Sexual difficulty/pain
- Type of birth control (if applicable):
Current: _____
Past: _____
- Adverse reactions to?* _____
- Date of last STD/STI testing? _____
- ___ Discharges or sores
- ___ Genital herpes
- ___ Condyloma/genital warts
- ___ Gonorrhea
- ___ Chlamydia
- ___ Syphilis
- ___ Other STD/STI: _____

MUSCULOSKELETAL

- ___ Arthritis
- ___ Broken bones
- ___ Joint pain/stiffness
- ___ Muscle pain
- ___ Muscle spasms/cramps

MUSCULOSKELETAL

- ___ Sciatica
- ___ Osteoporosis
- ___ Restless Leg Syndrome
- ___ Whiplash
- ___ Low back pain
- ___ Knee pain
- ___ Foot pain
- ___ Bunions
- ___ Wear corrective arches/orthotics
- ___ Swollen joints
- ___ Inflamed joints
- ___ Traumatic injury
- ___ Tendonitis
- ___ Bursitis
- ___ Herniated/slipped disc
- ___ Scoliosis
- ___ Ankylosing Spondylitis
- ___ Joint replacement _____

NEUROLOGICAL

- ___ Numbness/Tingling
- ___ Burning/shooting pains
- ___ Paralysis
- ___ Seizures/Epilepsy
- ___ Loss of balance
- ___ Tics
- ___ Trembling hands
- ___ Loss of grip strength
- ___ Loss of balance
- ___ Memory loss
- ___ Poor concentration

ENDOCRINE

- ___ Thyroid disease
- ___ Diabetes
- ___ Hypoglycemia
- ___ Seasonal depression
- ___ Fatigue upon exertion
- ___ Hair loss
- ___

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MEDICAL HISTORY ~5~

MENTAL/EMOTIONAL

- Mood Swings
- Poor concentration
- Irritability
- Anger
- Hallucinations (Auditory/Visual)
- Suicidal: attempted? _____
- Anxiety
- Attention Deficit/Hyperactivity
- Bipolar Depression
- Unipolar Depression
- Dysthymic disorder
- Mania
- Schizophrenia
- Panic Attacks
- Obsessive-Compulsive Disorder
- Post Traumatic Stress Disorder
- Other: _____

CHILDHOOD ILLNESSES

- Diptheria
- German Measles
- Measles
- Mumps
- Rheumatic fever
- Scarlet fever
- Other: _____

VACCINATIONS

- Measles, Mumps, Rubella (MMR)
- Polio
- Diptheria, Pertussis, Tetanus (DPT)
- Small pox
- Haemophilus Influenzae Type B
- Hepatitis A
- Hepatitis B
- Varicella (Chicken pox)
- Other: _____

Any adverse reactions to vaccinations:

IMMUNE

- Frequent colds
- Persistent infections
- Slow wound healing
- Swollen glands
- Chronic Fatigue Syndrome

ENVIRONMENT

- Mold/mildew at home
- Exposure to toxic chemicals
- Describe:* _____
- Exposure to second hand smoke
- Type of home heating: _____
- Drinking water: (*circle*) Tap/Filtered/Bottled
- Cookware: (*circle*) non-stick/Cast iron/ Pyrex aluminum/copper/ceramic/stainless steel

DIAGNOSTIC IMAGING

- Xray
- CT scan
- MRI
- Ultrasound
- Colonoscopy/Sigmoidoscopy
- Bone density scan
- Mammogram
- Electrocardiogram (EKG/ECG)
- Electroencephalogram
- Other _____

LABORATORY STUDIES

- Date last CBC/Chemistry panel: _____
- Any abnormal findings? _____

HOSPITALIZATIONS/SURGERIES

(Please list reason with date)

- _____
- _____

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