

This is a confidential record of your medical history and will be kept in this office. The information you provide herein will not be released to any person or entity without your authorization.

Name _____ Today's Date _____

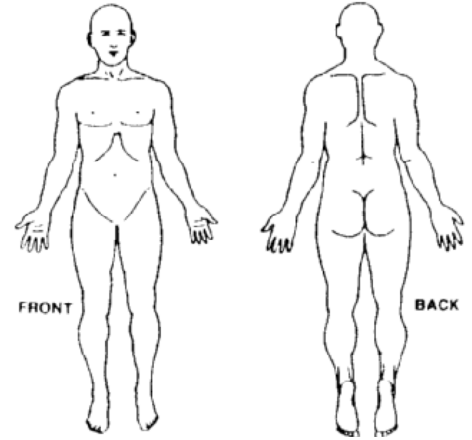
Date of Birth _____ Height _____ Weight _____

Marital Status: Single Married Divorced Other _____

Number of children and their ages _____ # Living with you? _____

Major Complaints:

Please mark your areas of pain



Date first occurred: _____ How often does it recur? _____

Pain is: Dull Moderate Severe And occurs: Constant Comes & Goes

Time of day pain is worst: _____ best: _____

Other Complaints:

Date first occurred: _____ How often does it recur? _____

List any medications / drugs / herbs you are currently taking: _____

List previous treatments for these complaints, including surgeries / operations, medications / herbs, and other therapies:

Medical History Do you have or have you ever had any of the following:

- Arthritis Asthma Anemia Chronic Fatigue Cancer Diabetes Epilepsy
- Stroke Kidney or Bladder problems Gallstones Ulcers High blood pressure
- Heart trouble Hepatitis Jaundice Sudden weight loss Sudden weight gain

Other condition: _____

Has any member of your family had any of the above? _____

(Over)

General Health

Energy Level Overall: High Adequate Low High time of day _____ Low time of day _____

Stress None Moderate Severe What causes it? _____

Circulation Overall, I feel: Hot Cold Just right My hands & feet are: Hot Cold Just right
 Night sweats Excessive sweating Rarely Sweat Bleed easily Cold limbs

Skin Dry Itchy Moist/Clammy Burning _____ Changing moles or lumps Cysts/tumors Boils
 Acne Frequent rashes on _____ Hives Skin puffy/wrinkled Bruise easily / black & blue spots
 Dry scalp Hair loss/thinning Dry/brittle nails Other: _____

Scars List all scars from accidents or medical treatments

Sleep Sleep deeply Sleep lightly Trouble falling asleep Trouble staying asleep Vivid/excessive dreams Snoring
How many hours do you sleep a night? _____ Other problems: _____

Head Dizziness Memory loss Poor balance Headaches - what area? _____

Eyes Eye pain Dry/itchy eyes Blurred vision Darkness under eyes Light sensitive Do you wear glasses or contacts
Have you ever had eye surgery or an eye disease? _____

Ears Poor hearing Earaches Ear discharge/infections Ringing in the ears: High pitch Low pitch Buzz Hum

Nose Frequent runny nose: Clear discharge Cloudy/thick discharge Frequent nose bleeds Frequent colds
 Sinus trouble Other problems: _____

Throat/Mouth Sore throat: time of day _____ Hoarseness Difficulty swallowing Jaw problems
 Dry mouth Swollen tongue Frequent mouth sores Frequent throat clearing or phlegm in throat

Chest Pain/pressure in chest Stitching pains in diaphragm Difficult breathing/wheezing: time of day _____
 Mucus rattles when breathing Palpitations Shallow breathing Coughing fits: time of day _____
 Persistent cough Frequent colds Coughing blood/phlegm: Color of sputum _____ Thick Thin

Blood Pressure Normal High Low Unknown

Bowels Diarrhea Constipation Alternating Bloody stools Mucus in stools Dry, hard stools Loose, watery stools
 Cramping in colon Hemorrhoids Lower bowel gas Stools have foul odor General stool color _____
Number of bowel movements per day _____ Other problems _____

Urine General color _____ Scanty Adequate Profuse Strong odor Blood in urine Pain or Burning
Frequent urination: Day Night Hard to urinate Frequent Infections Water retention

Musculoskeletal Pain in: Neck Shoulder Between shoulders Arms/Hands Fingers Hip Knee Big Toe
 Upper Back Mid Back Lower Back Bones sore/painful Loss of Grip Swollen knees/elbows
 Leg cramps at night Weakness in legs Weak ankles Stiff all over Muscle spasms/cramps
 Tingling in feet Loss of feeling in hands/feet Painful joints Bursitis Other _____

Neurological Nervous Depressed Easily angered Easily Irritated Fearful Frequent Crying Worry/Anxiety
 Mood Swings Memory confusion Poor concentration Suicidal Tremors Numbness/tingling in limbs
 Poor coordination Feel weak and shaky Seizures Neuralgia (nerve pain) Shingles Other _____

Females Pregnant? Y N Date of last period _____ Form of birth control _____
Age menses began _____ ended _____ Menstrual pain Low backache Irregular Clotting
 Heavy bleeding Scanty bleeding Color _____ Water retention Mood swings Food cravings
 Low or no sex drive Painful breasts Hot flashes Frequent vaginal infections Pain during intercourse
Discharges: Yellow Clear White Odor Itching Other _____
Pregnancies _____ # Deliveries _____ # Miscarriages _____ # Abortions _____ # Cesareans _____
Operations: Cervix Uterus Ovaries Explain _____

Males Low or no sex drive Impotence Pain after ejaculation Painful urination Premature ejaculation Discharges
 Prostate trouble Other _____

Dental Dental Pain Gum Problems Root Canals, # & Date _____ Metal Fillings, # & Date _____
 Wisdom Teeth Removed or Other Teeth Pulled, # & Date _____
 Abscess or Infections with Pulled Teeth "Dry Socket" with any Pulled Teeth, Date _____
 Other Tooth Loss, How? _____ Dentures / Bridgework TMJ Problems Other Dental Work

Digestion Stomach gas Lower bowel gas Heartburn Burning/belching Stomach pain Cramping Nausea
 Vomiting Bad breath Sores in mouth Weight gain Weight loss Bitter/sour taste in mouth Bloating
 Food allergies to _____ Other _____

Appetite Excessive appetite Poor appetite Appetite changes Feel tired or weak if a meal is missed Excessive thirst
 Rarely thirsty Crave hot, spicy foods Crave charred foods Crave cool drinks or juicy foods
Food cravings for _____

Nutrition Skip breakfast Light breakfast Hearty breakfast # of meals/snacks you eat per day _____
When is your biggest meal? _____ Always add salt at table
of glasses of water you drink per day _____ type: tap bottled filtered
 Drink coffee _____ cups per day Drink soda _____ per day Drink alcohol _____ drinks per week
List your favorite foods _____

Exercise How often do you exercise? _____ Exercise helps pain or aggravates pain
Favorite exercise/sports _____

Other comments / considerations:

Signature _____ **Date** _____