Name:_____ **Date:**_____

Medical History

Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

	Date Diagnosed		Date Diagnosed
Cancer type:	_____	HIV/Hepatitis	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Seizures	_____
Hepatitis	_____	Stroke	_____
High Blood Pressure	_____	Thyroid Disease	_____
High Cholesterol	_____	Other_____	_____

Please list any surgeries or major injuries with dates.

_____

_____

_____

List any medications or supplements you have taken in the last 2 months.

_____

_____

_____

Do you have a pacemaker or any metal devices in your body? Y / N

Family History

Indicate close family members with any of the following:

	Family Member(s)		Family Member(s)
Cancer (specify type)	_____	High Cholesterol	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Stroke	_____
High Blood Pressure	_____	Alcoholism	_____

Lifestyle Habits

Do you have and exercise routine? Please describe. _____

_____

How is your energy level? _____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

Nicotine Use: _____ Alcohol Use (#drinks/week and type): _____

Caffeine Use (#drinks/day and type): _____

Water intake (how much/day): _____

How do you prefer your water? (please circle one) Room temp/ cold/ hot

What color is your urine? (please circle one) Clear/ pale yellow/ bright yellow

Briefly describe your dietary habits (#meals/day and type of food)_____

_____

How is your digestion & elimination? _____

What flavor do you crave most? (please circle one) Salty/ sweet/ sour/ spicy or bland

Please check all that apply

Energy and Immunity

___ Fatigue
___ Allergies (Specify)_____
___ Anemia
___ Chronic Fatigue Syndrome
___ Thyroid Problems
___ Tendency to Catch Colds

Kidney/Urinary

___ Painful Urination
___ Frequent Urinary Tract Infections
___ Frequent/Urgent Urination
___ Edema/Swelling

Head, Eye, Ear, Nose, and Throat
___ Eye Dryness
___ Blurry Vision
___ Poor Night Vision
___ Ear Ringing
___ Hearing Difficulties
___ Headaches / Migraines
___ Teeth Grinding / TMJ
___ Sore Throat
___ Chronic Sinus Congestion
___ Dry Mouth
___ Bad Breath
___ Mouth Sores / Bleeding Gums
___ Increase in Thirst
___ Ringing in ears

Emotions / Sleep
___ Mood Swings
___ Anxious / Worried
___ Depressed
___ Irritable
___ Difficulty Making Decisions
___ Stressed
___ Insomnia
___ Nightmares
___ Difficulty Falling or Staying Asleep
___ Night Sweats

Respiratory/Cardiovascular
___ Shortness of Breath
___ Asthma
___ Chest Pain
___ Palpitations / Fluttering
___ Poor Circulations (Colds hands/feet)
___ Chronic Cough
___ Night Sweats
___ Unusual Sweating
___ Hot/Cold Intolerance

Gastrointestinal
___ Ulcers
___ Changes in Appetite
___ Nausea / Vomiting
___ Bloating / Pain
___ Gas
___ Heartburn / Acid Reflux
___ Belching
___ Hemorrhoids
___ Diarrhea
___ Constipation
___ Sudden Weight Change

Musculoskeletal

___ Neck / Shoulder Pain
___ Muscle Spasms / Cramps / Weakness
___ Arm Pain
___ Finger Pain / Tingling / Numbness
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Leg / Knee Pain
___ Foot / Ankle Pain
___ Hip / Pelvic Pain
___ Arthritis

Neurological
___ Vertigo / Dizziness
___ Numbness / Tingling
___ Difficulty Concentrating / Poor Memory

Skin
___ Rashes / Eczema / Hives / Psoriasis
___ Dry Hair or Hair Loss
___ Changes in Skin Color
___ Easy Bruising
___ Acne
___ Dry / Itchy Skin

Female Health
___ Irregular Cycle
___ Heavy Flow
___ Light Flow
___ Clots in Menstrual Blood
___ Menstrual Related Moodiness
___ Menstrual Related Breast Tenderness
___ Menstrual Related Bloating
___Bleeding Between Cycles
___Painful Periods (Is pain before, during and/or after after period?
___ Hot flashes
___ Vaginal Dryness
___ Breast Lumps / Cysts
___ Uterine Fibroids
___ Endometriosis
___ Ovarian Cysts
___ Unusual Vaginal Discharge Odor
___ Frequent Yeast Infections
___ Decreased Libido

Male Health
___ Prostate Enlargement
___ Impotence
___ Premature Ejaculation
___ Decreased Libido
___ Groin Pain