Name: ____________________________ Date: _______________

Medical History

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

	Date Diagnosed		Date Diagnosed
Cancer type:	_______________	HIV/Hepatitis:	_______________
Diabetes:	_______________	Mental Illness:	_______________
Heart Disease:	_______________	Seizures:	_______________
High Blood Pressure:	_______________	Stroke:	_______________
High Cholesterol:	_______________	Thyroid Disease:	_______________
Hepatitis:	_______________	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? **Yes / No**

Family History

Indicates 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 an exercise routine? Please describe. ____

____

How is your energy level? ____

How many hours per night do you sleep on average? _______________ Do you wake rested? **Yes / No**

Nicotine use: _______________ Alcohol use (#drinks/week and type): _______________________________

Caffeine use (#drinks/week 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 / 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 infection

__ 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
__ Increased thirst

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 circulation (cold hands/feet)
__ Chronic cough
__ Night sweats
__ Unusual sweating
__ Hot/Cold intolerance

Gastrointestinal

__ Sudden weight change
__ Ulcers
__ Changes in appetite
__ Nausea / Vomiting
__ Bloating / Pain
__ Gas
__ Heartburn / Acid reflex
__ Belching
__ Hemorrhoids
__ Diarrhea
__ Constipation

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
__ Decreased libido
__Frequent yeast infections
__ Unusual vaginal discharge odor
__ Ovarian cysts
__ Clots in menstrual blood
__ Menstrual related moodiness
__ Menstrual related breast tenderness
__ Menstrual related bloating
__ Bleeding between cycles
__ Painful periods?
(*before / during / and/or after period*)
__ Hot flashes
__ Vaginal dryness
__ Breast lump / cyst
__ Uterine fibroids
__ Endometriosis

Health History

Describe your current complaint: ____

Have you ever had prior treatment for this issue?____________________________________

How did it begin? ____

How long have you had it?____

Please rate your pain level 1 2 3 4 5 6 7 8 9 10

Please shade the areas where you feel pain.