Patient Information Form

Name_____Phone ©_____w_____
Address:
_____City_____ST_____Zip____
Gender_____Age_____Date of
Birth_____Height____Weight____
E-mail_____Marital Status_____Number of
Children____
Occupation_____Emergency
Contact_____
Referred
by?_____
A: Reason for visit today: (Describe your symptoms to the best of your ability):

_____

_____
B: Secondary Complaint(s) (List any other symptoms you are experiencing, whether or not it may seem related to your primary complaint):

_____
_____
_____
When did your primary complaint first
occur?_____
How long or how often has it been
occurring?_____
To what extent does this problem affect your daily activities (work, sleep, eating, energy, etc?)

_____
_____
When and under what circumstances does it seem to get better?

_____
Worse?

_____

Other concurrent therapies?

_____

_____

Are you under the care of a physician now?_____

Physician name_____ Physician Phone_____

MEDICAL HISTORY: (List relevant past illnesses, injuries, surgeries with dates)_____

_

_____

SIGNIFANT FAMILY MEDICAL HISTORY (List briefly and whom) ___

_____

_____

LIFESTYLE:

Do you follow a regular exercise program? (please describe)

_____

Sleep habits/hours of sleep/night:_____

Stress: (High, Low?)

_____

Please describe your average daily diet:

Breakfast:_____

__

Lunch:_____

_

Dinner:_____

_

Snacks:_____

_

Drinks:_____

Do you follow a particular diet or nutritional program? (i.e. Macrobiotic, vegan, anti-inflammatory etc.)

:_____

Do you generally cook your own meals?

_____

Please check the following habits that may apply. Indicate how much and often you consume them:

_____

Cigarettes_____ Coffee, tea or cola_____

Alcoholic beverages_____Recreational Substances_____

Medications taken within the last 2 months: (vitamins, drugs, herbs, etc.)_____

_____

Please put a check next to symptoms or conditions you have had and indicate how long you have had the symptoms or conditions:

GENERAL:

Poor appetite_____ Heavy appetite

_____

Strongly like Cold drinks_____ Strongly like hot drinks_____

Changes in appetite_____Cravings_____ Strong Thirst_____

Recent weight gain or loss_____ Poor sleep/Insomnia_____ Heavy sleep_____Dream-Disturbed sleep_____ Fatigue_____

Lack of strength_____Cold Hands or Feet _____ Bodily Heaviness_____Sweating easily_____Night sweats_____ Tremors _____

Fever _____Chills_____

Muscle cramps _____ Bleed or Bruise easily_____
Peculiar taste (describe)_____
Sudden energy drop? If so, time of day _____
Poor balance_____ Blood sugar Imbalance_____
Diabetes_____
Hypoglycemia_____
Allergies_____ Food Intolerance _____
Anemia_____ Enlarged Spleen _____ Enlarged Liver _____
Mononucleosis_____ HIV _____
AIDS_____
Thyroid problems (specify) _____
Hepatitis (specify A, B, C etc) _____ Gall stones _____
Kidney Stones_____ Jaundice _____ Glandular problems_____ Hormonal Imbalance _____
Arthritis_____ Autoimmune Disorder_____
How would you describe your sex drive?
High_____Avg_____Low_____
General energy level:_____

SKIN and HAIR:
Rashes _____ Hair Loss_____
Acne_____
Itching_____ Eczema _____ Hives _____
Dandruff _____ Ulcerations _____ Recent Moles _____

Fungal Infections_____
Psoriasis_____
Changes in skin or hair

_____
Any other hair or skin problem

_____

HEAD, EARS, EYES, NOSE and THROAT:
Glasses _____ Concussions_____ Eye strain

_____
Red or Itchy Eyes_____ Spots in Eyes

_____
Poor Vision_____ Poor Night Vision_____
Nosebleeds ___
Cataracts_____ Color Blindness_____ Eye
Pain_____
Headaches? (location of head, when, how
often?)_____

_____
Teeth problems_____Grinding teeth _____
TMJ_____ Facial pain_____ Gum
problems_____Excessive phlegm:
Color?_____ Chronic Sinus Infections:_____
Recurrent Sore Throats:_____ Swollen
glands_____
Lump in Throat_____ Sores on lips or
tongue_____
Ringing in the ears (Tinnitus): _____(if yes, pitch- low?
High? Volume- low? High? For how long?)

_____
Any other head or neck problems?

_____

RESPIRATORY:
Difficulty breathing when lying down_____ Shortness of
Breath____

Tight Chest_____ Asthma/Wheezing_____ Cough (wet or dry?_____ Thick or thin phlegm?
Color?_____
Coughing blood?_____
Pneumonia_____

CARDIOVASCULAR:

High blood pressure (Hypertension)
_____
Low blood pressure_____Orthostatic hypotension (dizzy when stand up?) _____ Chest pain_____
Irregular hearbeat:_____
Tachycardia_____
Heart palpitations (can you feel heart beat?)_____
Blood clots or phlebitis_____ Dizziness_____Poor circulation____

GASTROINTESTINAL:

Nausea_____ Vomiting_____ Acid Regurgitation_____
Gas_____Hiccup_____ Bloating_____Bad Breath____
Fatigue after eating_____Diarrhea_____ Soft stools_____
Constipation_____ Laxative Use_____ Black stools_____
Bloody stools_____ Mucous in stools_____ Intestinal Pain or cramping_____Itchy anus_____ Burning anus_____
Rectal Pain_____ Hemorrhoid_____Anal Fissures_____
Bowel Movements: Frequency:_____
Color_____

Texture/form_____Sticky_____Complete?_____
Odor____

MUSCULOSKELETAL:

Neck/shoulder pain_____Muscle pain_____Upper back pain__
Lower back pain_____Joint pain_____Rib (hypochondriac) pain_____Limited Range of Motion_____ Limited use_____
Other_____

NEUROPSYCHOLOGICAL:

Numbness_____Tics_____Stroke_____
Seizures_____
Poor Memory_____Irritibility_____Depression_____
For how long?_____ Anxiety_____Easily Stressed_____Abuse Survivor_____Considered/attempted suicide_____Seeing a therapist_____ Other _____

GENITOURINARY:

Pain on urination_____Frequency_____Urgent_____Burning_____
Blood_____Unable to hold urine_____Incomplete_____
Bedwetting_____Wake to urinate at night_____Premature ejaculation_____Nocturnal emissions_____ Sexually Transmitted Disease

GYNECOLOGY:

Age menses began_____Length of cycle (Day 1 to Day 1)_____
Duration of flow_____Irregular periods_____Painful periods Clots_____ Color_____PMS_____Vaginal Discharge_____
Vaginal sores_____Odor_____Breast lumps_____Age at Menopause_
Menopausal symptoms_____ #or pregnancies_____#live births_____
Date of last PAP_____Normal?_____Day of cycle_____