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Client Information:

Name: _____ Date: _____

Street Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell #: _____ email: _____

Employer: _____ Family Doctor: _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____ Male____ Female_____

Single_____ Partnered _____ Married _____ Divorced_____ Widowed_____

Personal Health Assessment

Reproductive Health (Female Only)

Yes No

Do you have irregular cycles during menstruation?
Do you have excessive bleeding during menstruation?
Do your breasts get extremely sore during menstruation?
Have you ever had an abnormal Pap exam? If yes, when? _____
What was done about the abnormal test _____
When was your last Pap test done?
Have you ever had ovarian cysts?
Have you ever had fibroid cysts?
Have you ever had endometriosis?
Have you had difficulty conceiving children?
Have you had a D & C?
Have you had a miscarriage?
Have you had a hysterectomy? When? _____ Partial _____ Complete_____
Do you have fibromyalgia?
Do you have low sex drive or excessive sex drive? If yes, circle one: Low or High

Reproductive Health (Male Only)

Yes No

Do you have to urinate often? If yes, how often in day? _____

Do you have prostate cancer? PSA count _____

Do you have an enlarged testicle?

Have you had a prostate exam? If yes, when as done_____

Do you have a low sex drive?

Do you have an excessive sex drive?

Do you have erection problems?

Do you have premature ejaculation?

List any other complications or problems not listed above that you are experiencing.

_____

Endocrine System (Adrenal "Medulla" Glands)

Yes No

Do you have M. S., Parkinson, or Palsy? If yes, please circle which one. MS Parkinson Palsy

Do you feel overly anxious or have anxiety attacks?

Do you feel excessive shyness, or feel inferior to others?

Is the systolic (top) number of your blood pressure reading low (below 118)?

Do you have tremors or nervous legs?

Do you have tinnitus (ringing in your ears)?

Do you have shortness of breath or is it hard to take a deep breath.

Do you have or had heart arrhythmias?

Do you have a hard time sleeping?

Do you have Chronic Fatigue Syndrome?

Do you get tired easily?

Have you ever been diagnosed with Addison's Disease?

Have you ever been diagnosed with Congenital Adrenal Hyperplasis?

Endocrine System (Adrenal "Cortex" Glands)

Yes No

Do you have elevated blood cholesterol levels?

Do you have lower back weakness?

Do you have or have you had sciatica?

Do you have arthritis or bursitis? If yes, circle which one. Arthritis Bursitis

Do you have any inflammatory conditions? If yes, please explain _____

_____

Endocrine System (Thyroid/ Parathyroid)

Yes No

Do you consider yourself overweight?

Have you gained weight recently without changing your lifestyle?

Is it hard to lose weight even on a diet?

Have you lost weight recently without trying or wanting to?

Do you consider yourself underweight?

Is it hard to gain weight?

Do you get cold hands and/or feet?

Have you had hair loss recently?

Are your fingernails ridged, brittle, or weak?

Do you have varicose or spider veins?

Do you have hemorrhoids?

Do you get muscle cramps often?

Do you have a problem with bladder leakage?

Do you have an irregular heartbeat?

Do you have a heart murmur (Mitral Valve Prolapse)?

Do you get headaches or migraines often? How often? circle one monthly weekly daily

Have you ever had a hernia?

Have you ever had an aneurysm?

Is your calcium levels low?

Is your bone density level low? When was your last bone density scan done? _____

Do you have spine deterioration?

Do you have any herniated discs?

Do you have osteoporosis?

Do you have scoliosis (curving of the spine)?

Do you get irritable easily?

Do you have low energy levels?

Do you have memory loss or "brain fog"?

Do you suffer from symptoms of depression?

Have you ever had a goiter?

Have you been diagnosed with hyperthyroidism?

Have you been diagnosed with hypothyroidism?

Have you been diagnosed with Graves' disease? When was antibody test done?_____

Have you been diagnosed with Hashimoto disease? When was antibody test done?_____

Have you been diagnosed with Reidel disease?

Do you sweat an extreme amount?

Do you hardly ever sweat?

Endocrine System (Pancreas)

Yes No

Do you get gas after you eat?

Do you feel as if your food just sits in your stomach?

Do you have Acid Reflux (GERD)?

Do you see any undigested foods in your stools?

Do you have low blood sugar (hypoglycemia)?

Do you have high blood sugar (diabetes)? If yes, circle which one. **Type 1** **Type 2**

Are you thin and have a hard time gaining weight?

Do you have gastritis or enteritis? If yes, circle which one. **Gastritis** **Enteritis**

Do you have diarrhea right after you eat?

Have you ever been diagnosed with Pancreatitis? If yes, when? _____

List any other complications or problems not listed above that you are experiencing.

_____

_____

Digestive System (Gastro-Intestinal Tract)

Yes No

Is your tongue coated (white, yellow, green, or brown) in the morning?

Do your have a Hiatus Hernia?

Do you have Celiac disease?

Do you have abdominal swelling after eating? If yes, how long after eating? _____

Do you have colitis?

Do you have diverticulitis?

Do you get diarrhea? If yes, circle how often. _____

Do you get constipation? If yes, circle how often. _____

Have you ever had stomach or intestinal ulcers? If yes, circle which one. **stomach** **intestinal**

Do you have Crohn's disease?

Do you have problems with too much "gas"?

Do you know your current cholesterol levels? If yes, please fill in. LDL _____ HDL _____

Do you have abnormal stools? Circle all that apply. **blood** **excess mucus** **float** **discolored**

How often do you have a bowel movement normally? _____

Do you have or have you had any type of gastro-intestinal (stomach, colon, rectal) cancers?

If yes, please explain the type of gastro-intestinal cancer and any treatment you received:

_____

_____

Have you ever had a colonoscopy? If yes, when? _____

What were the results? _____

Digestive System (Liver/ Gallbladder)

Yes No

Do you have a problem digesting fats?

Do fats or dairy foods cause bloating and/or pain in the stomach area?

Do your stools look white or very light brown in color?

Do you get pain in the middle of you back especially after eating?

Do you get pain behind the right, lower rib area?

Do you have "liver" or brown spots on your skin? (*not freckles*)

Do you have any skin pigmentation changes?

Do you have skin problems? If yes, please list. _____

Do you have or have you ever had hepatitis? If yes, circle which one. A B C

Do you have a blood disorder? If yes, circle which one? anemia sickle cell thalassemia

List any other complications or problems not listed above that you are experiencing, including ADHD, OCD or ADD diagnoses.

_____

Circulatory System (Heart)

Yes No

Do you have any gray hair?

Do you have a hard time remembering things?

Do your legs get tired or cramp after you walk?

Do you bruise easily?

Do you get chest pains or angina?

Do you have heart arrhythmias? If yes, what kind? _____

Do your have a heart murmur or Mitral Valve Prolapse?

Do you ever feel pressure on your chest?

Do you have or have you ever had high blood pressure?

Do you get "prickly" pains anywhere on your body, especially the heart area.

If yes, on what part of your body do you feel these pains? _____

Have you ever had a heart attack (myocardial infarction)?

Have you ever had open-heart surgery?

What is your average blood pressure? _____

List any other complications or problems not listed above that you are experiencing.

_____

_____

Integumentary System (Skin)

Yes No

Do you get or have skin rashes?

Do you have eczema?

Do you have dermatitis?

Do you have psoriasis?

Do you have dry skin?

Do you have dandruff?

Is your skin very oily?

List any other complications or problems not listed above that you are experiencing.

_____

Lymphatic System

Yes No

Do you have allergies?

Do you ever get cold or flu-like symptoms?

Do you have sinus problems?

Do you have or get sore throats?

Do you have swollen lymph nodes?

Do you have a low platelet count (blood)?

Do you have a low or sluggish immune system?

Do you get boils, pimples, or anything like them?

Do you have or ever had abscesses?

Do you have or ever had cellulitis?

Do you have or ever had gout?

Do you get blurred vision?

Do you have mucus in your eyes when you wake up in the morning?

Do you snore?

Do you have sleep apnea? If yes, do you use a CPAP? _____

Have you had appendicitis or an appendectomy? If yes, when? _____

Have you ever had toxemia?

Have you had your tonsils out? If yes, at what age did this happen? _____

List any other complications or problems not listed above that you are experiencing.

_____

Urinary System (Kidneys and Bladder)

Yes No

Do you have or have you had a urinary (kidney or bladder) infection?

Do you have or have you had "burning" upon urination?

Do you have problems holding your bladder?

Do you have or have you had kidney stones?

Do you have bags under your eyes, especially in the morning?

Do you get cramping or pain on the left or right side of your mid-to-lower back?

Do you have or have you had nephritis?

Do you have or have you had cystitis?

Is your urine flow restricted?

How much water do you drink in a day? _____ glasses

List any other complications or problems not listed above that you are experiencing.

_____

Respiratory System (Lung)

Yes No

Do you or have you worked around toxic chemicals, in coal mines, or around asbestos?

Do you or have you smoked? If yes, how often? _____

Do you have pain when you breathe?

Do you have pain when you take a deep breath?

Do you cough a lot?

Do you get any mucus when you cough? If yes, what color is it? _____

Do you get, have, or have had bronchitis?

Do you have or have had pneumonia?

Do you get, have, or have had emphysema?

Do you get, have, or have had asthma?

Do you get, have, or have had C.O.P.D.?

Do you have a collapsed lung?

Do you have or have you had lung cancer? If yes, when? _____

Are you on an inhaler? If yes, how often do you use it? _____

Are you on a nebulizer? If yes, how often do you use it? _____

Are you on oxygen?

Do you know what your oxygen saturation is? If yes, please list. _____

List any other complications or problems not listed above that you are experiencing.

Health History

Family History

Please fill out your family's medical history below.

Family Member	*Health Status*	*Arthritis*	*Cancer List type*	*Diabetes*	*Heart Disease List type*	*Lung Disease*	*Mental Illness*	*Other*	*Cause of Death*	*Age at Death*
Example: grandfather	deceased	no	brain	no	yes/stroke	no	no	gall bladder disease	brain tumor	52
Grandparents										
Parents										
Siblings										
Children										

Please list any past surgeries you have had such as hysterectomy, tonsils removed, etc.

Year	Surgery

Allergies

Please list any allergies you have.

Allergy (bees, pollen, asprin)	**How does it affect you? (rash, watery eyes, stop breathing)**

Medications

Please list medications (prescription) you are taking.

Medication	**How often?**	**Why are you taking this medication? example: high blood pressure**

Supplements

Please list any natural supplements (eg., vitamins, minerals, amino acids, fish oil, ect) you are taking.

Supplement	How often?	Why are you taking this supplement? example: stop constipation