MEDICAL HISTORY RECORD

Last Name:	First:	Middle:	Today's Date:	
___ Male ___ Female	Age:	Birth Date:	Occupation:	Children: No Yes: M: _____ F: _____
Address:	City:	State:	Zip:	Marital Status: M S D W P
Daytime phone: ( )	Home phone: ( )	Cell Phone: ( )		
Person to notify in emergency:	Phone: ( )	Relationship:		
Last Physical Exam Date:	Email:			
Doctor's Phone: ( )	Doctor's office location:			
May I contact this doctor for past health records? Yes No	How did you hear about us?			

Please check any that pertain to you (checking them will not make you ineligible for treatment, but it may restrict some of our treatment modalities):

Pregnancy Hepatitis HIV High Blood Pressure Recent Surgery Cancer Seizures Pacemaker Blood-Thinning Meds

What is the reason for your visit today?

PAST AND PRESENT MEDICAL PROBLEMS

PLEASE CHECK (✓) ALL SYMPTOMS THAT HAVE OCCURRED IN THE PAST YEAR
PLEASE CIRCLE SYMPTOM IF IT IS ALSO CURRENT:

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Swollen glands
- ☐ Poor memory
- ☐ Recent memory problems
- ☐ Concentration problems
- ☐ General weakness
- ☐ Aches/pains
- ☐ Recurrent infections
- ☐ Frequent colds
- ☐ Night sweats
- ☐ Excess daytime sweating
- ☐ Hot flashes
- ☐ Fatigue
- ☐ Fatigue, chronic
- ☐ Very sluggish, tired
- ☐ Insomnia
- ☐ Nightmares
- ☐ Tremors
- ☐ Poor balance
- ☐ Overweight
- ☐ Underweight
- ☐ Anorexia Nervosa, Bulemia
- ☐ Recent weight loss/gain
- ☐ History of dieting
- ☐ Afternoon fatigue
- ☐ Most always cold
- ☐ Too warm most of the time
- ☐ Cold hands/feet
- ☐ Sick more than 1 time per year
- ☐ Cancer or tumors
- ☐ Leukemia
- ☐ Polio
- ☐ Vivid dreams/nightmares
- ☐ Strongly like hot drinks
- ☐ Strongly like cold drinks
- ☐ Dizziness, vertigo
- ☐ Chemical sensitivities

HEAD
- ☐ Severe headaches
- ☐ Headache, chronic
- ☐ Migraines
- ☐ Dizziness
- ☐ Vertigo
- ☐ Hair loss
- ☐ Fainting
- ☐ Stroke: date: _____

NECK
- ☐ Stiffness
- ☐ Pain
- ☐ Trauma
- ☐ Swollen glands

EARS
- ☐ Ear drainage
- ☐ Ringing/buzzing in ears, Tinnitus
- ☐ Deafness in either ear
- ☐ Ear pain
- ☐ Itchy ears
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Hearing aids

NOSE & SINUSES
- ☐ Sinus problem
- ☐ Congested nose/sinuses
- ☐ Nosebleeds
- ☐ Discharge from nose
- ☐ Loss of smell

EYES
- ☐ Wear glasses/contact lenses
- ☐ Double vision
- ☐ Light flashes
- ☐ Blurred vision without glasses
- ☐ Vision loss
- ☐ Halos around lights
- ☐ Eye pain
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blindness in either eye
- ☐ Excessive tears
- ☐ Dry eyes
- ☐ Poor night vision

MOUTH & THROAT
- ☐ Tonsillitis
- ☐ Tooth pain
- ☐ Tooth abscess
- ☐ Tongue pain
- ☐ Jaw pain
- ☐ Jaw clicks
- ☐ Facial pain
- ☐ Thyroid, overactive
- ☐ Thyroid, under active
- ☐ Gum problems
- ☐ Sores on mouth/lips/tongue
- ☐ Swallowing difficulties
- ☐ Recurrent sore throat
- ☐ Persistent hoarseness
- ☐ Speech problems
- ☐ Loss of voice
- ☐ Goiter
- ☐ Bad breath
- ☐ Tongue feels swollen/thick
- ☐ Loss of taste
- ☐ Inflamed/bleeding gums
- ☐ Mercury fillings: #: _____
- ☐ Mercury fillings removed: date: _____

HEART & CHEST
- ☐ Heart disease
- ☐ High glucose
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Heaviness in legs
- ☐ Swollen ankles, legs, edema
- ☐ Swollen hands or feet
- ☐ Blood clots (heart, legs, etc.)
- ☐ Poor circulation
- ☐ Poor blood clotting
- ☐ Palpitations
- ☐ Heart flutters
- ☐ Irregular heartbeat
- ☐ Heart murmur as Adult
- ☐ Enlarged heart
- ☐ Dizziness upon standing
- ☐ Exhaustion with minor exertion
- ☐ Heart attack
- ☐ Chest tightness
- ☐ Chest pains/Angina
- ☐ Purple fingers/lips
- ☐ Calf pain at night
- ☐ Calf pain walking
- ☐ Varicose veins
- ☐ Anemia- type: _____

LUNGS & RESPIRATORY
- ☐ Allergies
- ☐ Hay fever
- ☐ Asthma
- ☐ Sinusitis
- ☐ Emphysema
- ☐ Difficulty breathing
- ☐ Difficulty breathing when lying dow
- ☐ Shortness of breath
- ☐ Shallow breathing
- ☐ Pain with breathing
- ☐ Bronchitis: Acute or Chronic
- ☐ Lung disease
- ☐ Recurrent cough
- ☐ Cough up blood
- ☐ Cough, chronic
- ☐ History of smoking
- ☐ Wheezing
- ☐ Tight chest
- ☐ Pneumonia
- ☐ Exposure to chemicals
- ☐ History of second-hand smoke
- ☐ Positive TB test

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Changes in appetite
- ☐ Bloating
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Dysentery
- ☐ Vomiting
- ☐ Gas/flatulence
- ☐ Burping, belching
- ☐ Hiccups
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Cirrhosis of liver
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Gallbladder disease, gall stones
- ☐ Diabetes
- ☐ Gout
- ☐ Heartburn, reflux
- ☐ Acid regurgitation

PAST AND PRESENT MEDICAL PROBLEMS (CONTINUED)

- ☐ Ulcers
- ☐ Ulcerative colitis, Chrohn's Disease
- ☐ Colon or bowel troubles
- ☐ Irritable Bowel Syndrome
- ☐ Constipation (<1 stool/day)
- ☐ Stools are hard to pass
- ☐ Strong odor to stools
- ☐ Diarrhea
- ☐ Loose stools (break up when hit water)
- ☐ Blood in stools
- ☐ Mucus in stool
- ☐ Anal itching
- ☐ Hemorrhoids
- ☐ Rectal pain, troubles
- ☐ Intolerance to specific foods
- ☐ Fatigue after eating
- ☐ Food sensitivity
- ☐ Treated for Parasites

GENITO-URINARY

- ☐ Bladder problems
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Problem passing urine
- ☐ Sense of full bladder
- ☐ Pain or burning with urination
- ☐ Up at night to urinate
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney disorder, stones
- ☐ Unable to hold urine
- ☐ Leakage with cough or sneeze
- ☐ Incomplete urination
- ☐ Increased libido
- ☐ Low libido
- ☐ Infertility
- ☐ Pain with intercourse

SKIN

- ☐ Acne
- ☐ Rash
- ☐ Eczema
- ☐ Hives
- ☐ Psoriasis
- ☐ Dry skin
- ☐ Recurrent boils
- ☐ Skin disease
- ☐ Bruise easily
- ☐ Changes in moles
- ☐ New lumps
- ☐ Itching
- ☐ Athlete's Foot

NEUROLOGICAL

- ☐ Fainting spells
- ☐ Seizures
- ☐ Tremors
- ☐ Bell's Palsy
- ☐ Numbness/tingling
- ☐ Heavy extremities
- ☐ Loss of muscle tone
- ☐ Loss of grip strength
- ☐ Paralysis
- ☐ Nerve damage
- ☐ Nerve disorder
- ☐ Poor coordination
- ☐ Sleep troubles
- ☐ Sleep disorder
- ☐ Sleep Apnea
- ☐ Other: _____

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Low back pain
- ☐ Upper back pain
- ☐ Neck pain
- ☐ Head trauma/injury/concussion
- ☐ Shoulder pain
- ☐ Frozen shoulder
- ☐ Elbow/forearm pain
- ☐ Hand/wrist pain
- ☐ Carpal Tunnel Syndrome
- ☐ Tarsal Tunnel Syndrome
- ☐ Rib pain
- ☐ Knee pain
- ☐ Hip/buttocks pain
- ☐ Sciatica
- ☐ Leg/thigh pain
- ☐ Foot/ankle pain
- ☐ Spasms
- ☐ Sore muscles
- ☐ Leg or arm weakness
- ☐ Limited range of motion
- ☐ Muscle lump or swelling
- ☐ Lump on bone
- ☐ Torn tissue
- ☐ Hernia
- ☐ Broken Bones
- ☐ Scoliosis

INFECTION & SCREENING

- ☐ Rheumatic Fever
- ☐ Chicken Pox
- ☐ Shingles
- ☐ Tuberculosis
- ☐ HIV risks: self or partner
- ☐ TB: self or household
- ☐ Hepatitis: type:
- ☐ Hepatitis risk: self or partner
- ☐ History of Sexually Transmitted Disease: self or partner
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Genital warts
- ☐ Herpes: oral or genital
- ☐ Other:

PSYCHOLOGICAL

- ☐ Depression
- ☐ Anxiety
- ☐ Irrational fears
- ☐ Excessive worry
- ☐ Easily upset
- ☐ Easily angered
- ☐ Serious emotional problems
- ☐ Jumpy, nervous, anxious
- ☐ Panic attacks
- ☐ Mood swings, irritability
- ☐ Easily susceptible to stress
- ☐ Attempted suicide
- ☐ Seriously considered suicide
- ☐ Feel lonely
- ☐ Substance abuse, addiction
- ☐ Substance use

WOMEN ONLY

- ☐ PMS
- ☐ Irregular menses
- ☐ Menstrual difficulties
- ☐ Painful menses
- ☐ Light menses
- ☐ Heavy menses
- ☐ Menstrual blood clots
- ☐ Non-menses bleeding/spotting
- ☐ Change in periods
- ☐ Vaginal discharge
- ☐ Cystitis, Fibroids
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Cervical problems
- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Nipple Discharge
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Pain with intercourse
- ☐ Vaginal dryness

MEN ONLY

- ☐ Groin pain
- ☐ Delayed urination
- ☐ Dribbling
- ☐ Incontinence
- ☐ Prostate troubles
- ☐ Retention of urine
- ☐ Lump in testicles
- ☐ Testicular cancer
- ☐ Sore on Penis
- ☐ Penis discharge
- ☐ Impotence
- ☐ Loss of sexual activity
- ☐ Erection difficulties
- ☐ Hernia (rupture) date: _____
- ☐ Premature ejaculation
- ☐ Bleeding after intercourse

OPERATIONS/SURGERIES
Please list all operations/surgeries and their dates:

Other **operations/surgeries** & dates:

Do you have **metal** components in your body? Yes No
If yes, where?

Do you have any **artificial** components in your body? Yes No
If yes, where?

Do you have a **pacemaker**? Yes Date received:

Any **car accidents** & dates:

Diseases requiring hospitalization & dates:

Any serious **illnesses** (not requiring hospitalization) & dates:

MEDICATIONS Check (✓) if currently taking	✓		✓
Antacids		Hormones	
Antibiotics		Insulin, Diabetic Pills	
Antidepressants		Iron or Poor Blood Meds	
Aspirin, Bufferin, Anacin		B12 shots	
Barbiturates		Laxatives	
Birth Control Pills		Phenobarbital	
Blood Pressure Pills		Sedatives, Anti-Anxiety Meds	
Blood Thinning Pills		Seizure Medication	
Cortisone		Sleeping Pills	
Cough Medicine		Thyroid Medicine	
Digitalis		Tranquilizers	
Dilantin		Vitamins	
Herbal Medicine		Water Pills	
Homeopathic Medicine		Weight Reduction Meds	

Other (list):

IMMUNIZATIONS	**YES**	**NO**	**DATE(S)**
Tetanus			
Flu Shots			

Other (list):

HABITS	YES	DAILY CONSUMPTION
Smoke		
Coffee		
Alcohol		
Tea (black, green)		
Artificial Sweetener		
Chocolate		
Soft Drinks		
Recreational Drugs		
Sugar		

WOMEN ONLY		
Last Gynecological Exam Date:		
Last Mammogram Date:		
Are you still having regular monthly menstrual cycles?	Yes	No
Have you ever had bleeding between your periods?	Yes	No
Do you have heavy bleeding with your periods?	Yes	No
Do you feel bloated and irritable before your period?	Yes	No
Are you taking or have you ever taken the birth control pill?	Yes	No
Dates on birth control pill:		
Last Date of Menstruation:		
Age Menses Started:	Age Menses Stopped:	
Number of pregnancies:		
Number of children: _____ female _____ male		
Number of miscarriages:	Number of abortions:	
Number of Cesarean operations:		
Any complications with pregnancies:		
Other Female Troubles:		

MEN ONLY
Last Prostate Exam Date:
Other Male Troubles:

Do you have **allergies**? Yes No
If yes, please list:

Do you wear **artificial devices**? Yes No
If yes, please list:

Do you **exercise**? Yes, Regularly No, Rarely Irregularly
If yes, how many minutes:
How often: Daily 1-3 times per week 4+ times per week
Method(s):

How many hours do you **sleep** at night?
Quality of sleep: Excellent Good Fair Poor

OTHER THERAPIES Check (✓) all items for all therapies you are receiving or have received	YES Present	YES Past
Acupuncture		
Chiropractic		
Hot Packs		
Ice Packs		
Massage/Neuromuscular Therapy		
Physical/Occupational Therapy		
Nutritional Therapy		
Aerobics/Fitness		
Yoga/Pilates		
Tai Chi/Qi Gong/Meditation		
Craniosacral Therapy		
Energy Work (Reiki, etc.)		
Tens/Electrostimulation/Cold Laser		
Psychotherapy/Counseling		
Other:		

DAILY ACTIVITES

	Daily	Weekly	Monthly	Never
Eat whole grains				
Eat red meat				
Eat fresh vegetables				
Eat fresh fruits				
Eat dairy products				
Eat refined grain				
Eat products with sugar added				
Brush teeth				
Dental floss				
Take time for yourself				

Please indicate the amount per day for the following:
hours sleep:
bowel movements (how often?):
times urination (daytime):
times urination (nighttime):
meals:
8 oz. glasses of water:
hours driving car:

Foods you crave (i.e. chocolate, sweets, salt, sour, breads, fatty/rich, spicy foods):