

MEDICAL HISTORY RECORD

Last Name:		First:	Middle:	Today's Date:	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age:	Birth Date:	Occupation:	Children: <input type="checkbox"/> No <input type="checkbox"/> Yes: M: _____ F: _____
Address:			City:	State:	Zip:
Daytime phone: ()		Home phone: ()		Cell Phone: ()	
Person to notify in emergency:			Phone: ()		Relationship:
Last Physical Exam Date:		Last Colonoscopy Exam Date:		By Doctor:	
Doctor's Phone: ()			Doctor's office location:		
May I contact this doctor for past health records? <input type="checkbox"/> Yes <input type="checkbox"/> 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):					
<input type="checkbox"/> Pregnancy <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Recent Surgery <input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Pacemaker <input type="checkbox"/> 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 <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Swollen glands <input type="checkbox"/> Poor memory <input type="checkbox"/> Recent memory problems <input type="checkbox"/> Concentration problems <input type="checkbox"/> General weakness <input type="checkbox"/> Aches/pains <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Frequent colds <input type="checkbox"/> Night sweats <input type="checkbox"/> Excess daytime sweating <input type="checkbox"/> Hot flashes <input type="checkbox"/> Fatigue <input type="checkbox"/> Fatigue, chronic <input type="checkbox"/> Very sluggish, tired <input type="checkbox"/> Insomnia <input type="checkbox"/> Nightmares <input type="checkbox"/> Tremors <input type="checkbox"/> Poor balance <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Anorexia Nervosa, Bulimia <input type="checkbox"/> Recent weight loss/gain <input type="checkbox"/> History of dieting <input type="checkbox"/> Afternoon fatigue <input type="checkbox"/> Most always cold <input type="checkbox"/> Too warm most of the time <input type="checkbox"/> Cold hands/feet <input type="checkbox"/> Sick more than 1 time per year <input type="checkbox"/> Cancer or tumors <input type="checkbox"/> Leukemia <input type="checkbox"/> Polio <input type="checkbox"/> Vivid dreams/nightmares <input type="checkbox"/> Strongly like hot drinks <input type="checkbox"/> Strongly like cold drinks <input type="checkbox"/> Dizziness, vertigo <input type="checkbox"/> Chemical sensitivities HEAD <input type="checkbox"/> Severe headaches <input type="checkbox"/> Headache, chronic <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo	<input type="checkbox"/> Hair loss <input type="checkbox"/> Fainting <input type="checkbox"/> Stroke: date: _____ NECK <input type="checkbox"/> Stiffness <input type="checkbox"/> Pain <input type="checkbox"/> Trauma <input type="checkbox"/> Swollen glands EARS <input type="checkbox"/> Ear drainage <input type="checkbox"/> Ringing/buzzing in ears, Tinnitus <input type="checkbox"/> Deafness in either ear <input type="checkbox"/> Ear pain <input type="checkbox"/> Itchy ears <input type="checkbox"/> Ear infections <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aids NOSE & SINUSES <input type="checkbox"/> Sinus problem <input type="checkbox"/> Congested nose/sinuses <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Discharge from nose <input type="checkbox"/> Loss of smell EYES <input type="checkbox"/> Wear glasses/contact lenses <input type="checkbox"/> Double vision <input type="checkbox"/> Light flashes <input type="checkbox"/> Blurred vision without glasses <input type="checkbox"/> Vision loss <input type="checkbox"/> Halos around lights <input type="checkbox"/> Eye pain <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness in either eye <input type="checkbox"/> Excessive tears <input type="checkbox"/> Dry eyes <input type="checkbox"/> Poor night vision MOUTH & THROAT <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tooth pain <input type="checkbox"/> Tooth abscess <input type="checkbox"/> Tongue pain <input type="checkbox"/> Jaw pain <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Facial pain	<input type="checkbox"/> Thyroid, overactive <input type="checkbox"/> Thyroid, under active <input type="checkbox"/> Gum problems <input type="checkbox"/> Sores on mouth/lips/tongue <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Persistent hoarseness <input type="checkbox"/> Speech problems <input type="checkbox"/> Loss of voice <input type="checkbox"/> Goiter <input type="checkbox"/> Bad breath <input type="checkbox"/> Tongue feels swollen/thick <input type="checkbox"/> Loss of taste <input type="checkbox"/> Inflamed/bleeding gums <input type="checkbox"/> Mercury fillings: #: _____ <input type="checkbox"/> Mercury fillings removed: date: _____ HEART & CHEST <input type="checkbox"/> Heart disease <input type="checkbox"/> High glucose <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heaviness in legs <input type="checkbox"/> Swollen ankles, legs, edema <input type="checkbox"/> Swollen hands or feet <input type="checkbox"/> Blood clots (heart, legs, etc.) <input type="checkbox"/> Poor circulation <input type="checkbox"/> Poor blood clotting <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart flutters <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Heart murmur as Adult <input type="checkbox"/> Enlarged heart <input type="checkbox"/> Dizziness upon standing <input type="checkbox"/> Exhaustion with minor exertion <input type="checkbox"/> Heart attack <input type="checkbox"/> Chest tightness <input type="checkbox"/> Chest pains/Angina <input type="checkbox"/> Purple fingers/lips <input type="checkbox"/> Calf pain at night <input type="checkbox"/> Calf pain walking <input type="checkbox"/> Varicose veins <input type="checkbox"/> Anemia- type: _____	LUNGS & RESPIRATORY <input type="checkbox"/> Allergies <input type="checkbox"/> Hay fever <input type="checkbox"/> Asthma <input type="checkbox"/> Sinusitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Difficulty breathing when lying down <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Shallow breathing <input type="checkbox"/> Pain with breathing <input type="checkbox"/> Bronchitis: Acute or Chronic <input type="checkbox"/> Lung disease <input type="checkbox"/> Recurrent cough <input type="checkbox"/> Cough up blood <input type="checkbox"/> Cough, chronic <input type="checkbox"/> History of smoking <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest <input type="checkbox"/> Pneumonia <input type="checkbox"/> Exposure to chemicals <input type="checkbox"/> History of second-hand smoke <input type="checkbox"/> Positive TB test GASTROINTESTINAL <input type="checkbox"/> Poor appetite <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Changes in appetite <input type="checkbox"/> Bloating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Nausea <input type="checkbox"/> Dysentery <input type="checkbox"/> Vomiting <input type="checkbox"/> Gas/flatulence <input type="checkbox"/> Burping, belching <input type="checkbox"/> Hiccups <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Indigestion <input type="checkbox"/> Cirrhosis of liver <input type="checkbox"/> Liver disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gallbladder disease, gall stones <input type="checkbox"/> Diabetes <input type="checkbox"/> Gout <input type="checkbox"/> Heartburn, reflux <input type="checkbox"/> Acid regurgitation
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PAST AND PRESENT MEDICAL PROBLEMS (CONTINUED)

<input type="checkbox"/> Ulcers <input type="checkbox"/> Ulcerative colitis, Crohn's Disease <input type="checkbox"/> Colon or bowel troubles <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Constipation (<1 stool/day) <input type="checkbox"/> Stools are hard to pass <input type="checkbox"/> Strong odor to stools <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loose stools (break up when hit water) <input type="checkbox"/> Blood in stools <input type="checkbox"/> Mucus in stool <input type="checkbox"/> Anal itching <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal pain, troubles <input type="checkbox"/> Intolerance to specific foods <input type="checkbox"/> Fatigue after eating <input type="checkbox"/> Food sensitivity <input type="checkbox"/> Treated for Parasites GENITO-URINARY <input type="checkbox"/> Bladder problems <input type="checkbox"/> Urgent urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Problem passing urine <input type="checkbox"/> Sense of full bladder <input type="checkbox"/> Pain or burning with urination <input type="checkbox"/> Up at night to urinate <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney infection <input type="checkbox"/> Kidney disorder, stones <input type="checkbox"/> Unable to hold urine <input type="checkbox"/> Leakage with cough or sneeze <input type="checkbox"/> Incomplete urination <input type="checkbox"/> Increased libido <input type="checkbox"/> Low libido <input type="checkbox"/> Infertility <input type="checkbox"/> Pain with intercourse SKIN <input type="checkbox"/> Acne <input type="checkbox"/> Rash <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Dry skin	<input type="checkbox"/> Recurrent boils <input type="checkbox"/> Skin disease <input type="checkbox"/> Bruise easily <input type="checkbox"/> Changes in moles <input type="checkbox"/> New lumps <input type="checkbox"/> Itching <input type="checkbox"/> Athlete's Foot NEUROLOGICAL <input type="checkbox"/> Fainting spells <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Bell's Palsy <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Heavy extremities <input type="checkbox"/> Loss of muscle tone <input type="checkbox"/> Loss of grip strength <input type="checkbox"/> Paralysis <input type="checkbox"/> Nerve damage <input type="checkbox"/> Nerve disorder <input type="checkbox"/> Poor coordination <input type="checkbox"/> Sleep troubles <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other: _____ MUSCULOSKELETAL <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Low back pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Head trauma/injury/concussion <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Frozen shoulder <input type="checkbox"/> Elbow/forearm pain <input type="checkbox"/> Hand/wrist pain <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Tarsal Tunnel Syndrome <input type="checkbox"/> Rib pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Hip/buttocks pain <input type="checkbox"/> Sciatica	<input type="checkbox"/> Leg/thigh pain <input type="checkbox"/> Foot/ankle pain <input type="checkbox"/> Spasms <input type="checkbox"/> Sore muscles <input type="checkbox"/> Leg or arm weakness <input type="checkbox"/> Limited range of motion <input type="checkbox"/> Muscle lump or swelling <input type="checkbox"/> Lump on bone <input type="checkbox"/> Torn tissue <input type="checkbox"/> Hernia <input type="checkbox"/> Broken Bones <input type="checkbox"/> Scoliosis INFECTION & SCREENING <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Shingles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV risks: self or partner <input type="checkbox"/> TB: self or household <input type="checkbox"/> Hepatitis: type: <input type="checkbox"/> Hepatitis risk: self or partner <input type="checkbox"/> History of Sexually Transmitted Disease: self or partner <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital warts <input type="checkbox"/> Herpes: oral or genital <input type="checkbox"/> Other: PSYCHOLOGICAL <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Irrational fears <input type="checkbox"/> Excessive worry <input type="checkbox"/> Easily upset <input type="checkbox"/> Easily angered <input type="checkbox"/> Serious emotional problems <input type="checkbox"/> Jumpy, nervous, anxious <input type="checkbox"/> Panic attacks <input type="checkbox"/> Mood swings, irritability <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Seriously considered suicide	<input type="checkbox"/> Feel lonely <input type="checkbox"/> Substance abuse, addiction <input type="checkbox"/> Substance use WOMEN ONLY <input type="checkbox"/> PMS <input type="checkbox"/> Irregular menses <input type="checkbox"/> Menstrual difficulties <input type="checkbox"/> Painful menses <input type="checkbox"/> Light menses <input type="checkbox"/> Heavy menses <input type="checkbox"/> Menstrual blood clots <input type="checkbox"/> Non-menses bleeding/spotting <input type="checkbox"/> Change in periods <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Cystitis, Fibroids <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Endometriosis <input type="checkbox"/> Cervical problems <input type="checkbox"/> Breast Lump <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Vaginal dryness MEN ONLY <input type="checkbox"/> Groin pain <input type="checkbox"/> Delayed urination <input type="checkbox"/> Dribbling <input type="checkbox"/> Incontinence <input type="checkbox"/> Prostate troubles <input type="checkbox"/> Retention of urine <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Testicular cancer <input type="checkbox"/> Sore on Penis <input type="checkbox"/> Penis discharge <input type="checkbox"/> Impotence <input type="checkbox"/> Loss of sexual activity <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Hernia (rupture) date: _____ <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Bleeding after intercourse
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OPERATIONS/SURGERIES
Please list all operations/surgeries and their dates:
Other operations/surgeries & dates:
Do you have metal components in your body? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?
Do you have any artificial components in your body? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?
Do you have a pacemaker ? <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had bleeding between your periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have heavy bleeding with your periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel bloated and irritable before your period? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you taking or have you ever taken the birth control pill? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:
Do you wear artificial devices ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:
Do you exercise ? <input type="checkbox"/> Yes, Regularly <input type="checkbox"/> No, Rarely <input type="checkbox"/> Irregularly If yes, how many minutes: How often: <input type="checkbox"/> Daily <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4+ times per week Method(s):
How many hours do you sleep at night? Quality of sleep: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

OTHER THERAPIES	YES Present	YES Past
Check (✓) all items for all therapies you are receiving or have received		
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 ACTIVITIES

	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):
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