

Name _____ Date of Birth _____
Address _____
Phone: Home _____ Office _____
E-Mail Address _____ Occupation _____
Emergency Contact _____
Emergency Contact's Phone _____ Relationship to You _____
Social Security # _____ Physician Name and Phone _____

Please list **any** prescription medicines you currently use.

Please list **any** over the counter medicines, recreational drugs or supplements you occasionally use or are currently using

Please list **any** surgeries that you have had whether related to this condition or not. Date of Surgery

What brings you to this office today? Has this condition been diagnosed by a physician?

Does anything improve this condition or make it worse?

Please "draw in" or "fill in" the area of concern, pain or discomfort regarding your visit today.



Please list any other health concerns or complaints even if not related to this condition

Do you experience any of the following symptoms? Please check all that apply even if they are not your chief complaint

PAIN / WEAKNESS SYMPTOMS

Muscle Pain/ Spasm _____
 Joint Pain/ Swelling _____
 Numbness, Tingling, Tremor _____
 Lower Back/ Knee Pain _____
 Weak/Fatigue with sexual activity _____
 Migratory Pain _____
 Other Pain: _____

RESPIRATORY SYMPTOMS

Cough _____
 Colds often and easily caught _____
 Nasal Congestion / Discharge _____
 Sinus Problems _____
 Sore throat _____
 Shortness of Breath _____
 Wheezing _____
 Tightness in Chest _____
 Difficult Breathing _____

GASTROINTESTINAL SYMPTOMS

Bloated Feeling _____
 Fatigue after eating _____
 Pain before/after eating _____
 Constipation _____
 Diarrhea _____
 Heartburn _____
 Stomachache _____

SLEEP

Unable to fall asleep _____
 Unable to stay asleep _____
 Violent Dreams _____
 Feel unrested after sleeping _____
 Night Sweats _____
 Wake to urinate _____

BODY TEMPERATURE

Feel too warm / cold _____
 Day Sweating with no exertion _____
 Night Sweating _____
 Chills / Fever _____
 Cold Hands / Feet _____
 Hand or feet sweating _____

HEART / BLOOD PRESSURE

Dizziness _____
 Shortness of Breath _____
 High / Low Blood Pressure _____
 Heart Palpitations _____
 Slow / Fast Heartbeat _____

HEAD

Eye Pain, Redness, Itching _____
 Ear Pain / Noise _____
 Headache _____
 Migraine Headache _____
 Hair Dryness / Loss _____
 Mouth / Lip Sores _____
 Blurry Vision _____
 Acne _____
 Dry / Bitter taste in mouth _____

URO-GENITAL SYMPTOMS

Painful or burning urination _____
 Frequent Urination _____
 Incontinence _____
 Blood in urine _____
 Dark colored urine _____
 Impotence _____
 Infertility _____
 Genital pain, itch or burning _____
 Vaginal Discharge _____

MENSTRUAL CYCLE

Irregular Cycle _____
 Infrequent Menstruation _____
 Short Menstrual Cycles _____
 Symptoms or pain related to menses _____
 PMS or any symptoms pre-menstrually _____
 Infertility _____
 Bleeding between periods _____
 Peri-Menopause / Menopause Symptoms _____

EMOTIONAL HEALTH

Stress _____
 Anxiety _____
 Depression _____
 Mood Swings _____
 Nervousness _____
 Worry _____
 Anger _____
 Mania _____
 Fear / Phobia _____
 Sadness / Grief _____

OTHER SYMPTOMS: Please List

PAIN AND WEAKNESS

Describe your muscle or joint pain

Is it stabbing, dull, throbbing? _____

Do you have swelling of joints or muscles? _____

Describe any numbness or tingling _Where & When _____

Does your pain move from one part of the body to another? Describe _____

Do you feel weak after resting, sexual activity, exercise? _____

RESPIRATORY SYMPTOMS

Do you smoke? How much? _____

Please describe your sinus/allergy problems _____

Describe your breathing difficulties _____

Do you have tightness / congestion / wheezing in your chest? _____

GASTROINTESTINAL

Is your pain/ discomfort worse before or after eating? _____

How often do you have a bowel movement? _____

DIET

Please list a typical days "menu".

Breakfast _____

Lunch _____

Dinner _____

Snack _____

Caffeine _____

Alcohol _____

Refined Sugar _____

Cold Drinks _____

Do you prefer cold or warm drinks? _____

SLEEP

How many hours of sleep do you typically get? _____

Do you wake frequently? _____

Why? _____

HEART / BLOOD PRESSURE

Do you know your blood pressure? _____

Have you ever had a heart attack? _____

Do you have any other heart disease? _____

HEAD

Please describe your headache pain _____

What part of the head hurts? _____

What brings them on? _____

Does anything alleviate them? _____

MENSTRUATION

Are you pregnant? _____
Are you trying to get pregnant? _____
Have you reached menopause? _____
How old were you when you began to menstruate? _____
How often do you menstruate? _____
How long does the menses last? _____

Do you experience:

Cramps before onset _____
Cramps during menses _____
Cramps after menses _____
Nausea before menses _____
Nausea during menses _____
Heavy bleeding _____

Do you experience:

Clotted bleeding _____
Overly-Emotional before / during _____
Crying _____
Irritability _____
Cravings _____
Water retention _____
Other menstrual related symptoms _____

Is your menstrual blood:

Light colored _____
Dark colored _____
Small, scant amount _____
Do you have a vaginal discharge? _____
What color is it? _____

OTHER SYMPTOMS

How would you rate your overall energy level? _____
Please describe any other symptoms that you feel are relevant to your current condition _____

Are there any factors in your life that you feel are presently causing stress or emotional upheaval?

Are you presently seeing a therapist for any emotional/mental issue ? _____

