Please help me provide you with a complete evaluation by taking the time (about 15 minutes) to fill out this questionnaire carefully. All answers are confidential.

Name: _____ Date _____

Address: _____ City:_____ State: _____ Zip:_____

Date of Birth: _____ Place of birth: _____ Age: _____Height: _____ Weight: _____

Telephone: Home ( )_____ Work ( )_____ Cell ( ) _____

Referred by:_____ Do you wish to receive the Monthly E-newsletter? Yes/No

Email: _____

Single _____Married _____Divorced _____Widowed _____ Living with _____

Education: _____ Occupation: _____

Children Names & Ages:

_____

_____

_____

_____

_____

Reason for visit today: _____

Other concerns: _____

How long have you had this condition?_____ Have you ever experienced this before?_____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your: Sleep ____Work____ Other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	Self	Mother	Father	Sibling	Spouse	Children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Age of death						
Hepatitis						
Kidney disorders						
Thyroid disorders						
Muscular-skeletal disorder						
Blood transfusion (if before 1985)						
Parkinson's disease						
AIDS						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs)_____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)

_____

_____

MEDICINES:

Medications you are taking & for what condition?		Herbs Vitamins
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

Year	Operation/Illness

Please put a "**C**" if the condition is current or a "**P**" if you had it in the past

General

___Insomnia
___Dreams/ nightmares
___Irritability
___Depression
___Mood swings
___Lethargy / Inertia
___Poor memory
___Difficulty making decisions
___Anxious or worried
___Hopeless or negative
___Cry easily
___ Fearful / Fearless
___Loose temper easily
___Difficult to accept sympathy
___Difficult to express joy
___Easily startled
___Extremely organized
___Spiritual
___Ever considered suicide
___Recent weight loss/gain
___Cold hands or feet
___Tends to push when exhausted
___Inflexible
___Lyme Disease
___Broken bones
___Nails split/crack
___Swelling of hands/feet
___Tumors / growths
___ Night sweating
___ Excess sweating
___ Difficulty being still / relaxing
___ Water retention / bloating
___Easily overheats or over chills
___Needs to sleep a lot

Head & Neck

___Headaches
___Migraines
___Stiff neck
___Dizziness
___Fainting
___Swollen glands
___Hair loss / thinning

Ears

___Ringing
___Hearing loss /Hearing aids
___Infections / Earache
___Vertigo
___Motion, air or seasickness

Eyes

___Glasses/ contact lenses
___Blurred vision / double vision
___Poor night vision
___Spots or floaters
___Eye inflammation
___Glaucoma / Cataracts
___Pain or itching
___Watery or too dry
___Recent laser surgery

Nose, Throat & Mouth

___Sinus infection
___Hay fever / allergies
___Frequent sore throat
___Difficulty swallowing
___Mouth & tongue ulcers
___Frequent colds
___Nosebleed / Dry nose
___Nasal congestion
___Loss of voice
___Thirst
___Excessive phlegm
___TMJ
___Facial pain
___Gum problems
___Dry mouth
___Loss of taste or smell

Skin

___Hives / Rashes
___Eczema/ Psoriasis
___Dry skin
___Easy bruising
___Changes in moles, lumps
___Itching
___Dandruff
___Recent Dermabrasion
___Recent Botox

Respiratory

___Difficulty breathing
___Wheezing
___Asthma
___Chronic cough
___Wet cough
___Dry cough
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Tight chest
___Pneumonia

Cardiovascular

___High / low blood pressure
___Chest pain or tightness
___Palpitation
___Rapid heart beat
___Irregular heart beat
___Poor circulation
___Swollen ankles / Phlebitis
___Anemia
___History of heart attack
___Varicose Veins

Gastrointestinal

___Nausea / vomiting
___Indigestion / slow digestion
___Stomach pain
___Diarrhea
___Constipation
___Poor appetite
___Excessive/ deficient hunger
___Flatulence
___Burping / Hiccups
___Acid regurgitation
___Bloating
___Laxative use
___Bloody stool
___Mucus in stool
___Hemorrhoids
___Liver / Gall Bladder disorder
___Colitis / Diverticulitis
___Crones
___Ulcer

Musculoskeletal Joint pain/disorder

___Sore muscles
___Weak muscles
___Difficulty walking
___Neck/shoulder pain
___Back pain
___Rib pain
___Limited range of motion
Other (describe)_____

Neurological

___Seizures
___Tremors
___Numbness or tingling
___Pain
___Paralysis
___Poor coordination
___Epilepsy or convulsions
___Fainting spells
Other (describe)_____

Genital-urinary

___ Pain on urination
___Frequent urination
___Urgent urination
___Blood in urine
___Unable to hold urine
___Incomplete urination
___Bedwetting
___Wake to urinate
___Increased libido
___Decreased libido
___Kidney stones
___Impotence
___Premature ejaculation
___Nocturnal emission
___Pain/itching of genitalia
___Lumps in testicles

Infection Screening

___Parasites
___HIV risks: self or partner
___TB: self or household
___Hepatitis risk: self or partner
___STD's: self or partner
___Genital warts
___Herpes: oral/ genital
Other:_____