

*All information on this form is completely confidential

Title & Name: _____ Phone #: _____

Street Address: _____

Postal Code: _____ City: _____

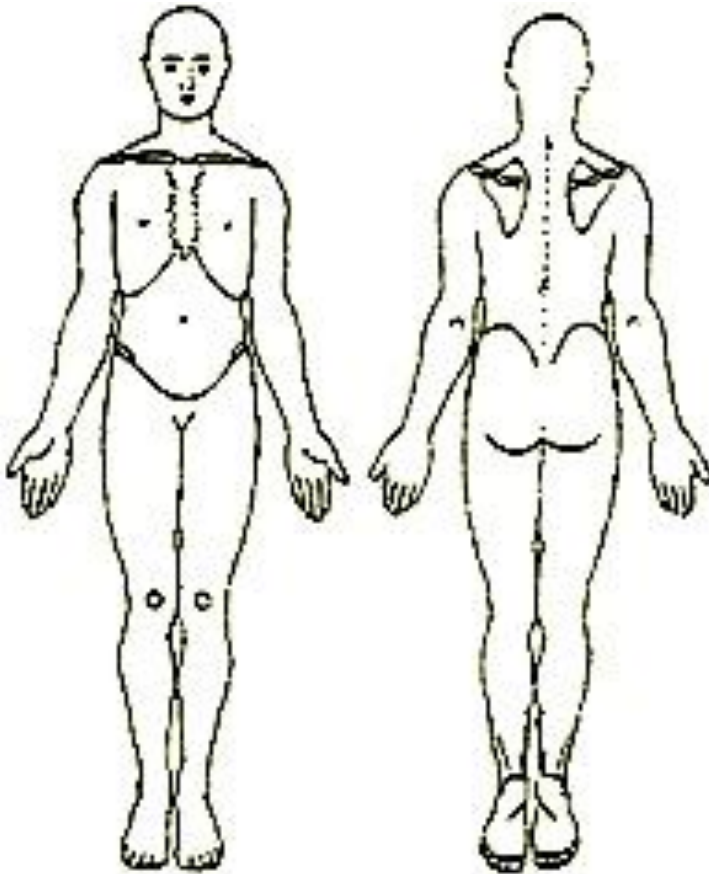
Occupation: _____ Height & Weight: _____

Birth Date: _____

Emergency Contact Name/Phone Number: _____

Please list the health issues you would like to address today:

Have you seen a doctor about this condition (yes or no): _____



On this diagram please shade in the areas that you experience pain and label them with the following letters:

- A = ache
- N = numbness
- B = burning
- P = pins and needles
- S = stabbing
- O = other

Please list any surgeries you have had:

Please list the date and events surrounding any traumatic event (fall, motor vehicle accident) which led to your current condition:

Please list any medications and supplements you are taking:

Please circle yes or no on the following:

Do you have a pacemaker: Yes / No

Do you have metal pins or plates in your body following surgery: Yes / No

Do you have any infectious disease at this time: Yes / No

Do you feel you have healthy eating habits: Yes / No

Do you have questions you would like to ask about your eating habits: Yes / No

If yes please list any questions you currently have:

Are you physically active: Yes / No

Please list what you currently do for exercise:

Please check off all boxes that apply to your current condition

Patient Medical History:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Past accidents or injuries | <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | |

Details:

Habits:

- | | | |
|--|---|---|
| <input type="checkbox"/> Addictive drugs | <input type="checkbox"/> Excess of alcohol | <input type="checkbox"/> Skipping meals |
| <input type="checkbox"/> Excess of salt | <input type="checkbox"/> Excess of caffeine | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Excess of sugar | <input type="checkbox"/> Late-night eating | <input type="checkbox"/> Other |

Details:

General Info:

- | | | |
|---|--|---|
| <input type="checkbox"/> Need to sleep a lot | <input type="checkbox"/> Chills, shivers | <input type="checkbox"/> Extreme thirst |
| <input type="checkbox"/> Disturbing dreams | <input type="checkbox"/> Cold abdomen or back | <input type="checkbox"/> Lack of thirst |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Hormone disorders |
| <input type="checkbox"/> Light sleeper | <input type="checkbox"/> Sweat easily or excessively | <input type="checkbox"/> Preference for warm drinks |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lack of sweating | <input type="checkbox"/> Preference for cold drinks |
| <input type="checkbox"/> Restless sleep | <input type="checkbox"/> Fainting | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sensitive to weather changes | | |

Details:

Hair and Skin:

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Brittle hair and nails |
| <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Itchiness | | |

Details:

Head and Neck:

- | | | |
|---|---|---|
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Gingivitis |
| <input type="checkbox"/> Blurred or weak vision | <input type="checkbox"/> Hearing disorders | <input type="checkbox"/> Tongue or mouth ulcers |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Low humming in ears | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bleeding from the gums |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Floaters in vision | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Dry throat |
| <input type="checkbox"/> Chronic runny nose | <input type="checkbox"/> Headaches, migraines | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Pain behind the eyes | <input type="checkbox"/> Swollen glands in neck |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus pressure or pain | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sinusitis | | |

Details:

Heart and Blood Vessels:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Edema | <input type="checkbox"/> Bleeding/clotting disorders |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Other |
| <input type="checkbox"/> Palpitations | | |

Details:

Lungs:

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dry Cough | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Heavy breathing | <input type="checkbox"/> Cough with white phlegm | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cough with yellow phlegm | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Other |
| <input type="checkbox"/> Wheezing | | |
| <input type="checkbox"/> Sneezing | | |

Details:

Urinary System:

- | | | |
|---|--|---|
| <input type="checkbox"/> Burning on urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Dark colored urine | <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Scant amounts of urine | <input type="checkbox"/> Light colored urine | <input type="checkbox"/> Frequent infections |

Details:

Musculoskeletal system:

- | | | |
|---|---|--|
| <input type="checkbox"/> Weakness in muscles | <input type="checkbox"/> Heaviness in limbs | <input type="checkbox"/> Joint disease |
| <input type="checkbox"/> Weakness in joints | <input type="checkbox"/> Tense neck | <input type="checkbox"/> Spinal column disorders |
| <input type="checkbox"/> Weakness in back | <input type="checkbox"/> Tense shoulders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pain in body (see chart) | <input type="checkbox"/> Tingling in limbs | <input type="checkbox"/> Other |

Details:

Digestion System:

- | | | |
|---|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Nausea | <input type="checkbox"/> Prolapse of organs |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cravings for bitter foods |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Cravings for sour foods |
| <input type="checkbox"/> Flatulence, bloating | <input type="checkbox"/> Belching/hiccups | <input type="checkbox"/> Cravings for sweet foods |
| <input type="checkbox"/> Hemorrhoids/piles | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cravings for salty foods |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Frequent bowel movements | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heartburn | | |

Details:

Neuro Psychology:

- | | | |
|---|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Difficulty in focusing | <input type="checkbox"/> Easily irritated |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fears | <input type="checkbox"/> Apathy |
| <input type="checkbox"/> Excessive worrying | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Oversensitivity |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Frequent sighing | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Other |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Anxiety | |

Details:

Women only:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormally long cycle | <input type="checkbox"/> Abnormally heavy flow | <input type="checkbox"/> Reoccurring infections |
| <input type="checkbox"/> Abnormally short cycle | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Menopausal syndrome |
| <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Clotted menstruation | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> PMS bloating | <input type="checkbox"/> Very dark menstruation | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> PMS mood swings | <input type="checkbox"/> Pale menstruation | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bleeding between periods | | |

Details: