

8. Please list any prescriptive medications, over-the-counter medications, vitamins, and supplements that you are currently taking and give your dosage: (Or provide a list of medications to your provider.)

9. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

10. Height: _____ Weight: Currently: _____ Past Maximum Weight: _____ When? _____

11. Blood Pressure: What is your most recent blood pressure reading? ____/____ When was this reading taken? _____

12. Immunizations (please circle any that you have had):

Polio Tetanus Measles/Mumps/ Rubella Pertussis Diphtheria Hepatitis B Others: _____

13. Family History:

	Mother	Father	Brothers	Sisters
Age if living:				
Health (G=good, P=poor)				
Age at death (if deceased)				
Cause of death				
Check off family illnesses:	Mother	Father	Brothers	Sisters
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Mental Illness				

14. Emotional - please circle any that you experience currently.

Mood Swings Depression Anxiety Mental Tension Past Traumas _____

15. Energy and Immunity - please circle any that you experience currently.

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Other _____

16. Head, Eye, Ear, Nose & Throat – please circle only ones that you experience currently.

Ear Ringing Headaches Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Hay Fever/Allergies

17. Respiratory - please circle any that you experience currently.

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough Asthma Other: _____

18. Cardiovascular - please circle any that you experience currently.

Heart Disease Chest Pain High Blood Pressure Palpitations/Fluttering Other: _____

19. Gastrointestinal - please circle any that you experience currently.

Nausea/Vomiting Epigastric or Abdominal Pain Heartburn Gall Bladder Disease Liver Disease

Hemorrhoids Chronic Diarrhea Chronic Constipation Blood in Stool Other: _____

20. Genito-Urinary Tract - please circle any that you experience currently.

Kidney Disease Painful Urination Blood in Urine Nighttime urination Incontinence Other: _____

21. Female Reproductive - please circle any that you experience currently.

Irregular Cycles Bleeding Between Cycles Vaginal Discharge Premenstrual Problems Menopausal Symptoms

Pelvic pain Infertility Other: _____

22. Menstrual/Birthing History:

No. of Pregnancies:		No. of Live Births:		No. of Miscarriages:	
No. of Days of Menses:		Days in Cycle:		Type of Birth Control, if any:	

23. Male Reproductive - please circle any that you experience currently.

Sexual Difficulties Prostate Problems Other: _____

24. Musculoskeletal - please circle any that you experience currently.

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain

Back Pain, if so, where?: _____ Joint Pain (if so, where?): _____

25. Neurological Problems - please circle any that you experience currently.

Vertigo/Dizziness Paralysis Numbness Loss of Balance Seizures Stroke Other _____

26. Endocrine and metabolic disorders - please circle any that you experience currently.

Hypothyroidism Hypoglycemia Hyperthyroidism Diabetes Mellitus Night Sweats Other _____

27. Other - please circle any that you experience currently.

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Other _____

28. Lifestyle:

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Daily Exercise: _____ Sleep: Good or Poor No. of Hours _____ Dreams: Y N

c. Occupation: _____ Employer: _____ Hours/Week: _____ Enjoy your work? Y N

d. Nicotine and Tobacco Use Per Day: _____

e. Alcohol Consumption Per Week: _____ Caffeine Consumption Per Week: _____