The information you give here will be held in the strictest confidence. Thank you for taking the time to fill out this form completely. Each item is important! If any item does not apply to you, leave it blank. Bring this form, along with a list of your medications and supplements with you to your appointment on:

Name _____ Today's Date _____

Height _____ Weight _____ Sex _____ Age _____ Marital Status _____

Date of Birth _____ Place of Birth _____

Occupation (if retired, former occupation) _____

Information regarding your immediate family's health:

Relationship:	Age if living:	Age at death:	State of health / Cause of death:
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Have any of your blood relatives had any of the following illnesses? If so, indicate the relationship (Father, Sister, etc.): If you were adopted, note your age at the time _____

Illness:	Family member(s):
ASTHMA	_____
ALLERGIES	_____
HIGH BLOOD PRESSURE	_____
HEART DISEASE	_____
STROKE	_____
DIABETES	_____
CANCER	_____
GLAUCOMA	_____
RHEUMATOID ARTHRITIS	_____
EPILEPSY	_____
MENTAL PROBLEMS	_____
SUICIDE	_____
ALCOHOLISM	_____

Note here all surgery, hospitalization, serious injuries or illness you have had:

Year:	Surgery, Illness or Injury:	Location (Town):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Here is an extensive list of conditions. Please read each one and if you have experienced any of them, **PROVIDE YOUR AGE** at the time and any comment you would like to make.

_____ ASTHMA
DIFFICULTY INHALING _____
DIFFICULTY EXHALING _____
_____ BRONCHITIS
_____ PNEUMONIA
_____ PLEURISY
_____ TUBERCULOSIS
_____ EMPHYSEMA
_____ ECZEMA / PSORIASIS
_____ SHINGLES / HERPES
_____ LOW BLOOD SUGAR
_____ DIABETES
_____ EATING DISORDER
_____ HEMORRHOIDS
_____ HERNIA
_____ PROLAPSE
_____ ULCER
_____ COLITIS
_____ DIVERTICULITIS
_____ HIGH THYROID
_____ LOW THYROID
_____ STREP THROAT
_____ RHEUMATIC FEVER
_____ HEART MURMUR
_____ ARTERIOSCLEROSIS
_____ HEART ATTACK
_____ STROKE
_____ BLADDER PROLAPSE
_____ BLADDER INFECTION
_____ KIDNEY INFECTION
_____ KIDNEY STONES
_____ PROTEIN IN URINE

_____ GLAUCOMA
_____ ARTHRITIS / GOUT
_____ GALL STONES
_____ HEPATITIS OR JAUNDICE
_____ PROLONGED COURSE OF ANTIBIOTICS
_____ PROLONGED COURSE OF STEROIDS
_____ ENVIRONMENTAL / CHEMICAL INJURY
_____ MULTIPLE CHEMICAL SENSITIVITY
_____ CHRONIC FATIGUE SYNDROME
_____ FIBROMYALGIA / MYOFASCIAL PAIN SYNDROME
_____ CANDIDA ALBICANS OR FUNGAL INFECTION
_____ MONONUCLEOSIS / EPSTEIN-BARR VIRUS
_____ LYME DISEASE
_____ POSITIVE HIV ANTIBODY TEST, ARC
_____ AUTOIMMUNE ILLNESS _____
_____ CANCER OR TUMOR
_____ GENETIC OR HEREDITARY CONDITION _____
_____ CONCUSSION
_____ COMA
_____ SEIZURE OR CONVULSION
_____ EXCESSIVE DRINKING OR DRUG HABIT
_____ MENTAL ILLNESS
_____ ATTEMPTED SUICIDE
_____ VERBAL ABUSE
_____ PHYSICAL ABUSE
_____ BIRTH TRAUMA _____

Childhood disease:
_____ CHICKEN POX
_____ MEASLES, GERMAN _____, RED _____
_____ MUMPS
_____ SCARLET FEVER
_____ POLIO

When was the last time you had the flu? _____
Years of military service: _____
Date of most recent dental work: _____ Number of root canals _____
Do you have pets? _____ If so, where do they sleep? _____

Have you recently had changes in your...? : If so, please explain:

Marriage/Partner YES _____
Job or Work YES _____
Residence YES _____
Financial Status YES _____

Please describe any other major stressors in your life:

_____

_____

_____

Here is an extensive list of symptoms. Please read each one and put a check by it if you experience it either **now** or if it is **common** for you:

_CHILLS
_FEVER
_DISLIKE OF WIND
_DISLIKE OF HEAT
_DISLIKE OF COLD
_SNEEZING
_RUNNY NOSE
_EXCESS MUCUS / CONGESTION
_LOSS OF SENSE OF SMELL
_LOSS OF SENSE OF TASTE
_SINUS BLOCKAGE
_SINUS INFECTION
_NOSEBLEED
_COUGH THAT IS PRODUCTIVE
_COUGH THAT IS DRY
_CHRONIC COUGH
_COUGHING BLOOD
_CHEST: TIGHT / FULLNESS
_SHORTNESS OF BREATH
_VERY DRY SKIN
_ITCHY SKIN
_FUNGUS INFECTION OF SKIN
_RASH / HIVES
_ACNE / BOILS
_MOLES CHANGING IN SIZE
OR IN COLOR
_SORES HEALING SLOWLY
_LYMPH NODES ENLARGED
_LUMPS UNDER SKIN
_GURGLING IN ABDOMEN
_GAS
_DIARRHEA:
_ " WATERY
_ " URGENT
_ " IN EARLY MORNING
_CONSTIPATION
_BOWEL MOVEMENT PAINFUL
_PAIN IN ABDOMEN
_GRIEF

_ANEMIA
_High blood pressure _____/____
_LOW BLOOD PRESSURE
_CHEST PAIN
_PALPITATIONS
_DIZZINESS
_FAINTING
_SORE THROAT
_COLD SORES: ON LIPS /
ON TONGUE / IN MOUTH
_RESTLESS SLEEP
_SLEEP APNEA
_INSOMNIA
_VIVID DISTURBING DREAMS
_PANIC ATTACKS
_ANXIETY

_LOSS OF APPETITE
_EXCESSIVE APPETITE
_LACK OF THIRST
_EXCESSIVE THIRST
_DRY MOUTH
_LOSS OF WEIGHT
_WEIGHT GAIN
_PREFER: HOT / COLD DRINKS
_DIFFICULTY SWALLOWING
_NAUSEA / VOMITING
_BELCHING
_JAW PAIN
_STOMACH ACHE
_HEARTBURN
_ABDOMEN BLOATED
_GUMS: SWOLLEN / BLEEDING
_EDEMA (SWELLING):
_ " WHOLE BODY
_ " UPPER BODY / NECK
_ " LOWER BODY / ANKLES
_BLOOD IN STOOL
_Undigested food in stool
_BLACK STOOL
_PALE STOOL
_BRUISING EASILY
_WASTING MUSCLES
_WEAK MUSCLES
_TIRING EASILY
_TIRED IN MORNING
_TIRED IN AFTERNOON
_GENERAL LETHARGY
_WORRY
_COMPULSIVENESS
_OBSESSIVENESS
_CAN'T SETTLE MIND
_HIGH STRUNG

_URINARY FREQUENCY
_PAIN ON URINATION
_DARK URINE
_REDDISH URINE
_CLOUDY URINE
_BURNING URINATION
_UP AT NIGHT TO URINATE
_Losing urine on straining
_SWEATING DURING THE DAY
_SWEATING WHEN AT REST
_SWEATING AT NIGHT
_LACK OF SWEATING
_RESTLESS LEGS
_LEG CRAMPS: NIGHT / DAY
_UNSTEADY ON FEET
_COORDINATION PROBLEMS
_NERVE PAIN
_PRICKING / TINGLING

_PAIN IN RIBS OR SIDES
_BREAST PAIN
_BRITTLE, SPLITTING NAILS
_WEAK HAND GRASP
_NECK: STIFF / PAINFUL
_SHOULDER: STIFF/ PAINFUL
_JOINTS: SWOLLEN / PAINFUL
_PAINFUL TO RAISE ARM
_LOOSE JOINTS
_HEADACHE / MIGRAINE
_EYE / VISION PROBLEMS:
_ " BLURRY / DOUBLE VISION
_ " NEAR / FAR SIGHTED
_ " RINGS AROUND LIGHTS
_DRY / ITCHY EYES
_WATERY EYES
_THROAT FEELS OBSTRUCTED
_INTOLERANCE OF CHEMICALS
_SHAKING OF LIMBS, BODY
_VARICOSE VEINS
_MUSCLE SPASMS
_NUMB HANDS OR FINGERS
_NUMB LEGS OR FEET
_OTHER NUMBNESS _____
_BITTER TASTE IN MOUTH
_GENITAL PAIN / PROBLEM
_MOODINESS
_ANGER
_IRRITABILITY
_LONELY
_DEPRESSION
_BOREDOM
_TROUBLE RELAXING
_INDECISIVENESS

_ODD GROWTH AS A CHILD
_Incomplete bone formation
_DIMINISHED SEX DRIVE
_INCREASED SEX DRIVE
_INABILITY TO CONCEIVE
_IMPOTENCE
_URETHRAL DISCHARGE
_COLD HANDS AND FEET
_THINNING BONES
_STIFF SPINE
_BACK PAIN - Upper, Middle, Lower
_HIP PAIN: RIGHT / LEFT
_KNEE PAIN: RIGHT / LEFT
_TEETH PROBLEMS
_HAIR LOSS
_LOSS OF HEARING
_RINGING IN EARS
_FEAR / DREAD
_HARD TO EXPRESS FEELINGS
_FORGETFULNESS

Other symptoms not listed above (please list your specific reason for seeking help on the last page):

_____

_____

Have you ever lived or worked...? (circle)		If so, for how long?
On a Farm	YES	_____
In a Mine, Laundry or Mill	YES	_____
In a Damp, Moldy place	YES	_____
In a very Dusty place	YES	_____
With or near Asbestos	YES	_____
With or near Radioactive Chemicals	YES	_____
With or near other Toxic Chemicals	YES	_____

WOMEN, please answer the following questions:

Age at onset of menstruation (moons): _____

Usual number of days in your monthly cycle: _____

USsual duration of blood flow: _____ days

Approximate date of last menstrual period: _____

Do you experience any of the following symptoms on your monthly cycle?

_____ EMOTIONAL UPS AND DOWNS
_____ DEPRESSION
_____ IRRITABILITY
_____ CRAVING OF SWEETS / SALT
_____ SKIN ERUPTIONS
_____ WATER RETENTION / BLOATING
_____ WEIGHT GAIN
_____ NAUSEA / VOMITING
_____ CONSTIPATION / DIARRHEA
_____ SWELLING OF BREASTS/TENDERNESS
_____ PAINFUL CRAMPS / ABDOMINAL PAIN
_____ LOW BACK ACHING
_____ EXCESS BLEEDING / CLOTS OR DARK FLOW
_____ SPOTTING / IRREGULAR PERIODS
_____ SKIPPED MENSTRUAL PERIOD

Give your age when you may have experienced any of the following conditions:

_____ Yeast Infection
_____ Vaginal Irritation/Dryness
_____ Painful Intercourse
_____ Breast Inflammation
_____ Ovarian Cyst
_____ Uterine Fibroid(s)
_____ Irregular Pap Smear
_____ HPV
_____ Pelvic Inflammatory Disease
_____ Endometriosis
_____ Hysterectomy, cause _____

Number of Pregnancies _____
Number of Miscarriages _____
Number of Abortions _____
Ectopic Pregnancies _____
Number of Children _____
Are you Pregnant now? _____
Do you examine your breasts for lumps regularly? _____

History of Birth Control method (Pills, IUD, diaphragm, etc.): _____

If applicable, age at Menopause: _____ List any menopause symptoms: _____

_____

MEN, please answer the following questions:

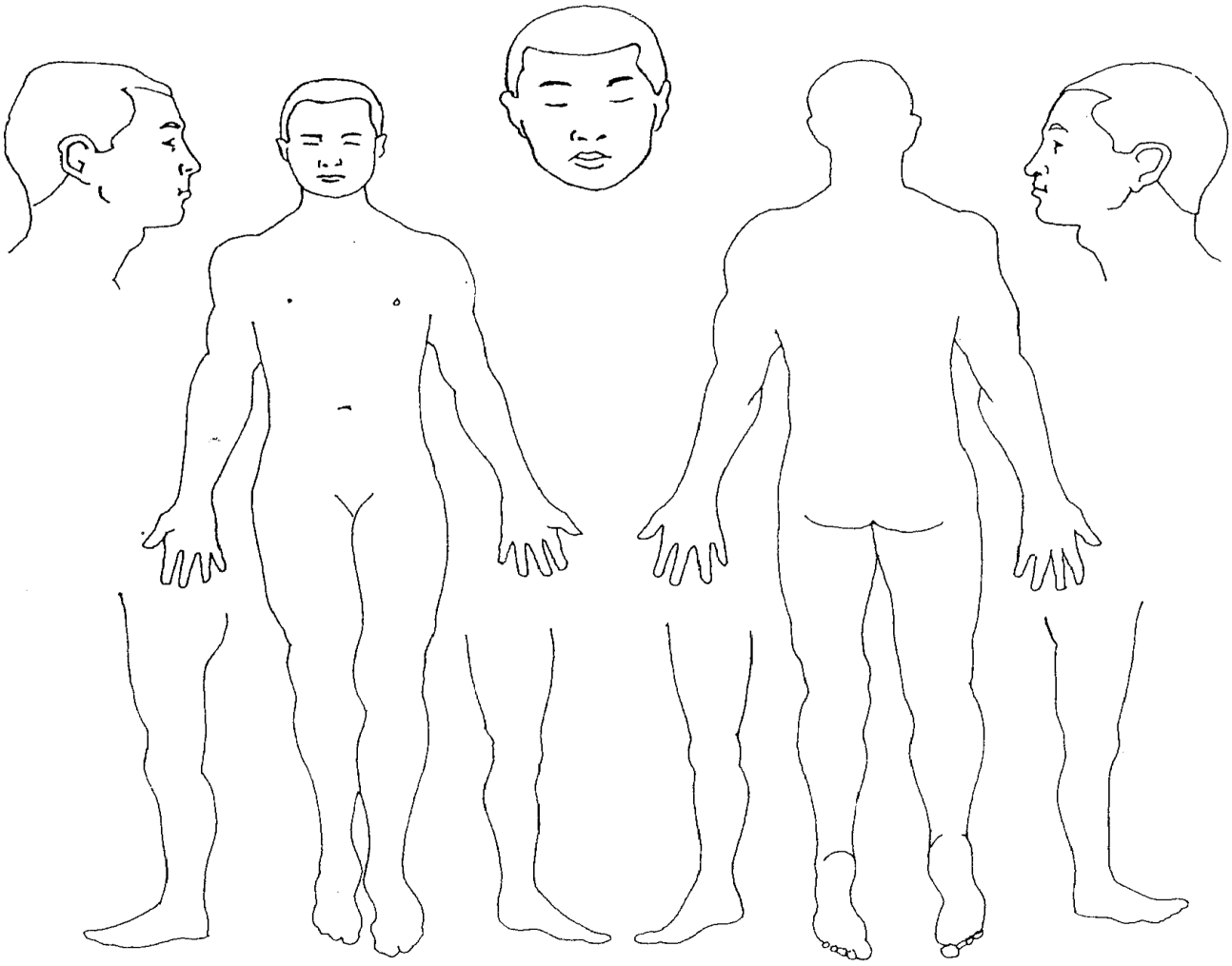
DO YOU EVERY HAVE PAIN, LUMPS OR SWELLING IN YOUR TESTICLES?_____

HAVE YOU HAD OR DO YOU HAVE AN ENLARGED PROSTATE? _____ PSA TEST LEVEL? _____

HAVE YOU HAD A VASECTOMY AND IF SO, WHEN? _____

PRESENT FORM OF BIRTH CONTROL: _____

On the figures below, please mark any areas where you experience pain or discomfort:



EXPLANATIONS: _____

_____

_____

_____

_____

	NO	YES	QUANTITY
Do you smoke cigarettes?	_____	_____	_____
Do you use cannabis?	_____	_____	_____
Do you use hard drugs?	_____	_____	_____
Do you drink alcohol?	_____	_____	_____
Do you drink caffeine drinks?	_____	_____	_____

Do you feel you have an addiction to any of the above substances? YES / NO

If yes, which ones? _____

How much do you exercise (circle)? Little or none / 1 – 3 Times per week / Over 3 times per week

What types of sports or exercise do you enjoy? _____

_____

Have you traveled outside the US in the last two years? YES / NO
If yes, where have you traveled? _____
Check the inoculations you have had:
FLU ____ ROTAVIRUS ____ TETANUS_____ TYPHOID ____ DIPHTHERIA ____ POLIO ____
YELLOW FEVER ____ HEPATITIS A ___ B ___ OTHER: _____
Have you had a Positive _____ OR Negative _____ Tuberculin (TB) Test?

Please write here what you actually ate in the previous 24-hour period, as completely as possible. Indicate the **source** of the food, e.g., restaurant, home made, brand name, and the time of day you ate the meal or snack.

Food and its source: Beverage: Snacks:

Breakfast:

TIME:

Lunch:

TIME:

Dinner:

TIME:

Is this a typical days diet? YES / NO Are you a vegetarian? YES / NO Vegan? YES / NO
How often do you eat out? _____

List all items to which you are allergic (foods, pollens, dust, drugs, chemicals, soaps, perfume, animals, bee stings, etc.) and indicate the reaction:

_____

_____

What foods do you crave? _____
What foods do you avoid? _____

_____

How much water do you drink per day? _____
If you know your blood type, circle: O A B AB rh+ rh-
List any disorders for which you are being treated by another health care practitioner:

Illness or disorder:	Practitioner Name:
_____	_____
_____	_____
_____	_____

How is your general health now? POOR _____ FAIR _____ GOOD _____ EXCELLENT _____
How has it been for most of your life? POOR _____ FAIR _____ GOOD _____ EXCELLENT _____

List the current health issues that you would like to address:	Date symptoms began: (exact date if due to accident)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE BRING A LIST OF YOUR MEDICINES AND SUPPLEMENTS TO YOUR APPOINTMENT.

Who may we thank for referring you to us? _____ *THANK YOU!*