



### **Outline Procedure for New Patients**

- Step One:** All new patients are requested to fill out a personal health questionnaire prior to their appointment.
- Step Two:** Your consultation with a doctor to discuss your health problems.
- Step Three:** Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if Chiropractic care is appropriate for your condition.
- Step Four:** You will be advised if there is the need of any additional procedures such as X-rays, MRI, & CAT Scan.
- Step Five:** If your case requires immediate attention, treatment will be administered.
- Step Six:** You will be advised as to a time you can return for your “Report of Findings” so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations in regards to your condition.
- Step Seven:** If appropriate, your treatment plan will begin following your “Report of Findings.”

## Confidential Patient Information

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cellular Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ May we send you newsletters and promotions via email? Yes \_\_\_\_ No \_\_\_\_

Marital Status \_\_\_\_ Name of Spouse \_\_\_\_\_ # of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

In case of emergency, please contact: Name \_\_\_\_\_ Phone # \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

Is your injury work related, and auto accident or personal injury? [ ] Yes [ ] No

If your injury is related to work, an auto accident or any other injury involving a claim, please advise the office staff.

Name of person responsible for payment \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Phone # \_\_\_\_\_

Name of the Insured \_\_\_\_\_ Birth Date of Insured \_\_\_\_\_ SS# of Insured \_\_\_\_\_

## Financial Policy

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Foothill Chiropractic** will gladly prepare any necessary reports and forms to assist me in making collection from my primary insurance carrier. If I am paying by cash, check or credit card or if I have insurance co-pay and/or deductible, payment is expected at the time of service. If I have insurance, I hereby authorize and direct my insurance carrier to pay benefits, which may be due to me, according to my policy, directly to, and payable to **Foothill Chiropractic** to be applied to my account. I understand and agree that all fees for services rendered on my behalf are my personal responsibility and are due and payable at time of service.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE. IF MY TREATMENT REQUIRES INSURANCE BILLING, I HEREBY AUTHORIZE AND DIRECT **FOOTHILL CHIROPRACTIC** TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (**Comprehensive Care**).

Foothill Chiropractic and Wellness Center stresses that it is always **YOUR** choice to choose which form of care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief Care  Corrective Care  Comprehensive Care  Would like to discuss options with the doctor

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### Please list your major health concerns in order of severity:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

#### **Complaint # 1:**

When did you first notice this condition? \_\_\_\_\_

Did it begin  Immediately or  Gradually? (please describe briefly) \_\_\_\_\_

What is the exact location of your symptoms? \_\_\_\_\_

Do your symptoms spread?  No  Yes Where? \_\_\_\_\_

How often do you experience these symptoms?

Constant  Frequent (75% of day)  Often (50%)  Seldom (25%)  Rarely (less than 25%)

Is this condition progressively  Worsening  Improving or  Unchanged

What is the intensity of your symptoms?  Severe  Moderate  Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain  Deep or  Superficial

Please indicate the character of your pain:  Dull  Sharp  Burning  Aching  Knife-like  Throbbing

Are you experiencing any of the following associated symptoms?  Pins & Needles  Tingling

Numbness  Twitching of muscles If yes, please describe: \_\_\_\_\_



**Complaint # 2:**

When did you first notice this condition? \_\_\_\_\_

Did it begin  Immediately or  Gradually? (please describe briefly) \_\_\_\_\_

What is the exact location of your symptoms? \_\_\_\_\_

Do your symptoms spread?  No  Yes Where? \_\_\_\_\_

How often do you experience these symptoms?  
 Constant  Frequent (75% of day)  Often (50%)  Seldom (25%)  Rarely (less than 25%)

Is this condition progressively  Worsening  Improving or  Unchanged

What is the intensity of your symptoms?  Severe  Moderate  Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain  Deep or  Superficial

Please indicate the character of your pain:  Dull  Sharp  Burning  Aching  Knife-like  Throbbing

Are you experiencing any of the following associated symptoms?  Pins & Needles  Tingling  
 Numbness  Twitching of muscles If yes, please describe: \_\_\_\_\_

Please indicate what activities provoke (P) or aggravate (A) your condition:  
 Sitting \_\_\_min  Lying  Lifting \_\_\_lbs.  Bowel Movements  Hot or Cold  
 Standing  Pushing  Gripping  Mental Activities  Walking  
 Pulling  Coughing/Sneezing  Bright Lights  Other (Please explain)\_\_\_\_\_

Please indicate what helps you to relieve the pain.  
 Lying  Walking  Rest  Medications \_\_\_\_\_  
 Sitting  Standing  Heat or Cold  Other (Please explain)\_\_\_\_\_

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

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Please include any other relevant history in regards to this complaint.

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**Complaint # 3:**

When did you first notice this condition? \_\_\_\_\_

Did it begin  Immediately or  Gradually? (please describe briefly) \_\_\_\_\_

What is the exact location of your symptoms? \_\_\_\_\_

Do your symptoms spread?  No  Yes Where? \_\_\_\_\_

How often do you experience these symptoms?  
 Constant  Frequent (75% of day)  Often (50%)  Seldom (25%)  Rarely (less than 25%)

\_\_\_\_\_  
Is this condition progressively  Worsening  Improving or  Unchanged

What is the intensity of your symptoms?  Severe  Moderate  Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain  Deep or  Superficial

Please indicate the character of your pain:  Dull  Sharp  Burning  Aching  Knife-like  Throbbing

Are you experiencing any of the following associated symptoms?  Pins & Needles  Tingling

Numbness  Twitching of muscles If yes, please describe: \_\_\_\_\_

Please indicate what activities provoke (P) or aggravate (A) your condition:

- Sitting \_\_\_min     Lying     Lifting \_\_\_\_\_lbs.     Bowel Movements     Hot or Cold
- Standing     Pushing     Gripping     Mental Activities     Walking
- Pulling     Coughing/Sneezing     Bright Lights     Other (Please explain)\_\_\_\_\_

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Please indicate what helps you to relieve the pain.

- Lying     Walking     Rest     Medications\_\_\_\_\_
- Sitting     Standing     Heat or Cold     Other (Please explain)\_\_\_\_\_

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Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

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Please include any other relevant history in regards to this complaint.

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## Past Medical History

Please include any of your previous conditions. If possible include dates, diagnosis, treatment received and any residuals you still suffer from.

### Utero, Birth, and Infancy:

Was your mother healthy when you were in utero?  Yes  No (Please explain \_\_\_\_\_)

Did she smoke or consume alcohol?  No  Yes

Where were you born? \_\_\_\_\_

Were you delivered vaginally or through cesarean section? *Circle one*

Were there any complications during your birth process?  No  Yes (Please explain) \_\_\_\_\_

Were you vaccinated?  No  Yes

Did you have normal neurological, structural, emotional, and social development?  Yes  No (Please explain) \_\_\_\_\_

Did you have any of the following:

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_

### Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, social, and academic development?

Yes  No \_\_\_\_\_

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_



**Teens (ages 13-19)**

Did you have normal neurological, structural, emotional, social, and academic development?

Yes  No \_\_\_\_\_  
\_\_\_\_\_

Please rate the following abilities and traits:

	<b>Excellent</b>	<b>Good</b>	<b>Average</b>	<b>Below Average</b>	<b>Poor</b>	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_

**Females only:** What age did you start your menses? \_\_\_\_  Regular  Irregular

**Twenties**

Please rate the following abilities and traits:

	<b>Excellent</b>	<b>Good</b>	<b>Average</b>	<b>Below Average</b>	<b>Poor</b>	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_

Work Injuries  none \_\_\_\_\_

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_

## Thirties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_

Work Injuries  none \_\_\_\_\_

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_

## Forties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_

Work Injuries  none \_\_\_\_\_

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_

**Females only:** Menopausal symptoms  none  yes \_\_\_\_\_

## Fifties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_

Work Injuries  none \_\_\_\_\_

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

Surgeries:  none \_\_\_\_\_

**Females only:** Menopausal symptoms  none  yes \_\_\_\_\_

## Sixties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_

Work Injuries  none \_\_\_\_\_

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

## Seventies

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_  
\_\_\_\_\_  
Work Injuries  none \_\_\_\_\_  
Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_  
\_\_\_\_\_  
Illnesses/Hospitalizations:  none \_\_\_\_\_  
\_\_\_\_\_

## Eighties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_  
\_\_\_\_\_  
Work Injuries  none \_\_\_\_\_  
Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_  
\_\_\_\_\_  
Illnesses/Hospitalizations:  none \_\_\_\_\_  
\_\_\_\_\_

## Nineties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents  none \_\_\_\_\_

Work Injuries  none \_\_\_\_\_

Injuries, Accidents, Falls or Traumas  none \_\_\_\_\_

Illnesses/Hospitalizations:  none \_\_\_\_\_

## Family History

**Mother**  Alive & Well, age \_\_\_  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Father**  Alive & Well, age \_\_\_  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Brother**  Alive & Well, age \_\_\_  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Brother**  Alive & Well, age \_\_\_  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Sister**  Alive & Well, age \_\_\_  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Sister**  Alive & Well, age \_\_\_  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Children:** Ages \_\_\_\_\_ Any health conditions? \_\_\_\_\_

**Maternal Grandmother**  A&W  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Maternal Grandfather**  A&W  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Paternal Grandmother**  A&W  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Paternal Grandfather**  A&W  Deceased age \_\_\_ from what? \_\_\_\_\_  
Any health conditions \_\_\_\_\_

**Have any of your family members ever suffered from any of the following conditions?**

Diabetes  Neurological Disorders \_\_\_\_\_  Depression/Mental Illness  
 Heart Disease  Autoimmune Diseases \_\_\_\_\_  Stroke  
 Cancer \_\_\_\_\_  Other \_\_\_\_\_

**Medications** Please list your current medications and the condition they are treating.

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**Vitamins and Minerals** Please list your current supplements and who prescribed them.

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## Habits

**Cigarettes**  none How many per week? \_\_\_\_\_ **Cigars**  none How many per week? \_\_\_\_\_  
**Alcohol**  none How many drinks per week? \_\_\_\_\_ Type of alcohol \_\_\_\_\_  
**Coffee**  none How many cups per week? \_\_\_\_\_  
**Recreational Drugs**  none Types \_\_\_\_\_ Frequency \_\_\_\_\_ Years of Usage \_\_\_\_\_  
**Exercise**  none Hours/Days per week \_\_\_\_\_ Types \_\_\_\_\_  
**Water**  none Glasses per day \_\_\_\_\_  
**Soft Drinks**  none Amount per week \_\_\_\_\_ Types \_\_\_\_\_  
**Sleep** Average per night \_\_\_\_\_ Do you have difficulty falling asleep or staying asleep?  Yes  No  
 Hours desired per night? \_\_\_\_\_  
**Meals per days** \_\_\_\_\_ What type of foods do you eat? \_\_\_\_\_  
 Do you consider your diet healthy?  Yes  No \_\_\_\_\_

## DATE OF LAST

**Physical Examination:** \_\_\_\_\_ By Whom? \_\_\_\_\_ Results \_\_\_\_\_  
**Blood Work:** \_\_\_\_\_ By Whom? \_\_\_\_\_ Results \_\_\_\_\_  
**Bone Density Study** \_\_\_\_\_ Results \_\_\_\_\_ **Mammogram** \_\_\_\_\_ Results \_\_\_\_\_  
**Pelvic Exam** \_\_\_\_\_ Results \_\_\_\_\_ **Self Breast Exam** \_\_\_\_\_ Regularity \_\_\_\_\_  
**PSA level** \_\_\_\_\_ Results \_\_\_\_\_ **Digital Prostate Examination** \_\_\_\_\_ Results \_\_\_\_\_  
**Chest X-rays** \_\_\_\_\_ Results \_\_\_\_\_ **EKG** \_\_\_\_\_ Results \_\_\_\_\_  
**Echocardiogram** \_\_\_\_\_ Results \_\_\_\_\_  
**Spinal X-rays** \_\_\_\_\_ By Whom? \_\_\_\_\_ Where are they located? \_\_\_\_\_  
**MRI / CAT Scan** \_\_\_\_\_ Re \_\_\_\_\_ Where are they located? \_\_\_\_\_  
**Other tests:** \_\_\_\_\_

**CHECK any of the following conditions you have HAD and CIRCLE anything you currently HAVE.**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Infective Diseases _____ |
| <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Tuberculosis       | <input type="checkbox"/> Fungal Infection _____   |
| <input type="checkbox"/> Tumors           | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Hepatitis _____    | <input type="checkbox"/> Herpes _____             |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Drug Addiction   | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Parasites          | <input type="checkbox"/> Autoimmune Disease       |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> _____                    |

### NERVOUS SYSTEM

- Depression
- Memory loss/Confusion
- Dizziness
- Fainting
- Convulsions
- Numbness
- Weakness
- Poor Balance/Coordination
- Twitches/Tremor
- Cold/Tingling Extremities
- Sleeping Difficulties
- Headaches

### C-V

- Chest Pain
- Irregular Heartbeat
- High Blood Pressure
- Shortness of Breath
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- GU**
- Discolored Urine
- Bladder Trouble
- Painful Urination
- Excessive Urination
- Incontinence

### EENT

- Vision Problems
- Flashing Lights
- Black Spots
- Blurriness
- Hearing Loss
- Ringing in Ears
- Swallowing Difficulty

**GI**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Frequent Diarrhea
- Frequent Constipation
- Hemorrhoids
- Abdominal Cramping
- Black/Bloody Stools
- Heartburn
- Digestive Problems
- Weight Problems
- Gas/Bloating After Meals
- Gall Bladder Problems
- Liver Problems

**MUSCULOSKELETAL**

- Jaw Pain
- Difficulty Chewing
- Face Pain
- Neck Pain
- Arm/Elbow Pain
- Wrist/Hand Pain
- Mid Back Pain
- Lower Back Pain
- Thigh/Knee Pain
- Ankle/Foot Pain
- Difficulty Walking
- Leg/Arm Fatigue

**REPRODUCTIVE**

- Erectile Difficulties
- Sexual Dysfunction
- Menstrual Irregularity
- Menstrual Cramping

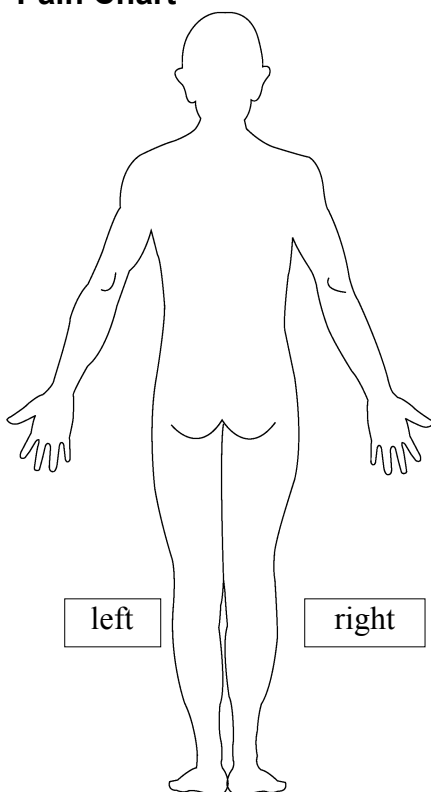
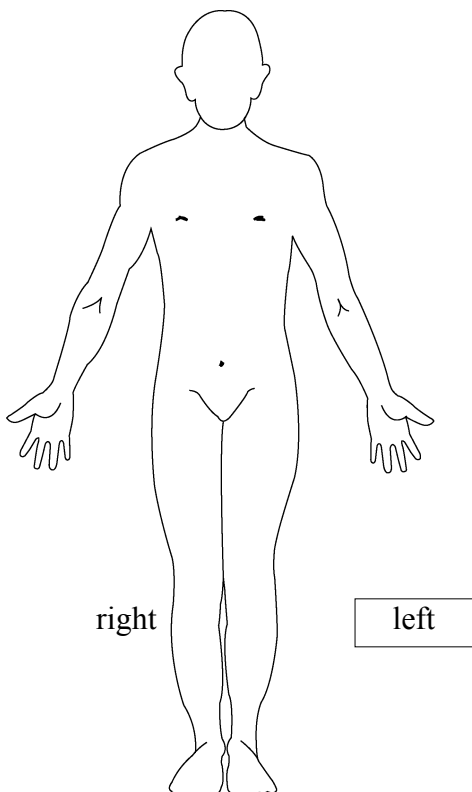
How often do you have a bowel movement? \_\_\_\_\_ Are your movements consistent?  Yes  No  
 Do your stools  float or  sink

How many times a day do you urinate? \_\_\_\_\_ Is this consistent?  Yes  No \_\_\_\_\_  
 Do you experience any urgency, dribbling, incontinence? \_\_\_\_\_

**Show Area(s) of Pain or Unusual Feeling**

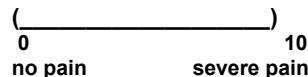
Mark the areas on this body where you feel pain or unusual sensations. Include all affected areas.

**Pain Chart**



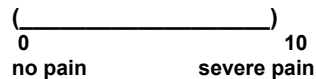
**Neck-Shoulder-Arm-Pain**

On a scale of zero to 10, I rate my discomfort as follows:



**Mid Back Pain**

On a scale of zero to 10, I rate my discomfort as follows:



**Low Back and Leg Pain**

On a scale of zero to 10, I rate my discomfort as follows:

