CONFIDENTIAL

name ______________________ (first & last) | name you would like to be called ________ | highest grade completed ________ | today's date ________

Do you have a primary health care provider? yes ☐ no ☐ name ______________________

specialty ______________________

date last consulted ______________________

date last physical exam ______________________

List practitioners you have seen in last 5 years

____

____

____

____

Concerns

List your main health concerns, in order of importance. for each one, describe: mo/yr of onset, how has it changed over time, what makes it better/worse and prior treatments/consultations

describe: ______________________

Goals

What goals/results do you hope to accomplish through your consultations here? ______________________

Meds, Etc.

check if you use:

- ☐ antacids
- ☐ aspirin
- ☐ birth control pills
- ☐ cold/allergy pills
- ☐ food supplements
- ☐ herbals
- ☐ hormones/glandulars
- ☐ laxatives
- ☐ minerals
- ☐ none of the above
- ☐ over-the-counter medicines
- ☐ pain pills
- ☐ prescription drugs
- ☐ sleeping pills
- ☐ tranquilizers
- ☐ vitamins
- ☐ other ______________________

checked items

name	dosage	frequency	name	dosage	frequency

please add extra page as needed, including all supplements

Allergies

- ☐ chemicals
- ☐ cosmetics/lotions
- ☐ drugs
- ☐ foods
- ☐ pollens/inhalants
- ☐ shots
- ☐ no known allergies
- ☐ other ______________________

checked items

food/substance	reaction

please complete the other side - add an extra page as needed

Physical height _______ weight _______ favorite weight _______

Have you had your blood pressure checked? yes _____ no _____ value _______ would you like these checked
Have you had your cholesterol checked? yes _____ no _____ value _______ at the clinic? yes_____ no _____

Stress Factors How much have the following been a concern for you? Please indicate on the scales with an x from 0 to 4 (0 = not a concern, 4 = very much a concern)

	0	1	2	3	4
stress					
concerns with work					
concerns about children					
emotional concerns					
family/marriage concerns					
alcohol					
misuse of drugs					
violence in the home					

Have you experienced a major life change within the last year?
yes _____ no _____ describe ____________________

List the **3** most stressful events in the past year:

Typical Day Describe a typical day within the past 2 weeks. briefly describe your day from the time you get up, activities throughout the day and finally bedtime.

Lifestyle/Habits

- yes ☐ no ☐ have you lost/gained more than 5 pounds in the past year? how much? ________
- yes ☐ no ☐ are you within 10% of your ideal weight?
- yes ☐ no ☐ do you eat at least 3 meals a day?
- yes ☐ no ☐ do you regularly eat breakfast?
- yes ☐ no ☐ do you consider your nutritional intake adequate? rate: poor ___ fair___ good ___ excellent ___
- yes ☐ no ☐ do you drink caffeinated beverages? coffee cups/day _____ tea cups/day_____ colas 12oz/day _____
- yes ☐ no ☐ do you drink alcoholic beverages? beers/wk _____ glasses wine/wk _____ mixed drinks/wk _____
- yes ☐ no ☐ do you use other intoxicants? what type? ____________
- yes ☐ no ☐ do you smoke/chew? what? ____________ packs/day _____ how many years _____
- yes ☐ no ☐ do you work around toxic substances? what? ____________
- yes ☐ no ☐ do you exercise regularly? how often ________ how long ________ times/wk _____ top 3 activities:
- yes ☐ no ☐ can you run 2 blocks or go up 2 flights of stairs without difficulty? 1 ________
- yes ☐ no ☐ do you routinely wear seat belts? 2 ________
- yes ☐ no ☐ do you sleep well and awaken rested? hours/night ________ 3 ________
- yes ☐ no ☐ do you have a regular spiritual practice? please describe: ____________
- yes ☐ no ☐ do you have a regular practice for stress management? Check those that apply: exercise _____ hobbies _____ meditation/prayer _____ yoga _____ other ____________

in general, how would you describe your health? poor _____ fair _____ good _____ excellent _____

Information Requests please check if you would like:

- ___ acupuncture
- ___ allergy/environmental sensitivity
- ___ healthful breathing habits
- ___ health habits rating: how risky is your lifestyle
- ___ healthy living habits/high level wellness
- ___ massage/body balancing
- ___ meditation and prayer
- ___ illness/diagnosis: what you can do
- ___ illness/diagnosis: understanding what's wrong
- ___ medications & prescriptions
- ___ mental/emotional health
- ___ nutrition/special diets
- ___ physical fitness/aerobic conditioning
- ___ stress management
- ___ vitamin supplementation
- ___ weight loss