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 _____ List practitioners you have seen in last 5 years

date last consulted _____ _____

_____

date last physical exam _____ _____

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

checked items

name	dosage	frequency	name	dosage	frequency

please add extra page as needed, including all supplements

Allergies

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