INITIAL HEALTH HISTORY Today's Date ____ / ____ / ____

PATIENT INFORMATION

Name:_____Birthdate _____ Gender: Male/Female

Address: _____ City: _____ State:___ Zip: _____

Phone (Home/Cell):_____ Email _____

Employer/School: _____ Occupation: _____

Work Activity:_____ Spouse name: _____ or N/A

CHILDREN & PREGNANCY

How many children do you have? _____ Are you currently pregnant? □ No □ Yes, I am due _____

Children's ages? _____ Number of past pregnancies? _____

Children's health concerns? _____ Health concerns regarding this pregnancy? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? **I would like ASSISTANCE with:**

☐ Think more clearly / focus ☐ Medication use ☐ Digestive Problems ☐ Sleep ☐ Immune system

☐ Pregnancy / Delivery ☐ Allergies ☐ Detoxification ☐ Mind ☐ Performance

☐ Inherited conditions ☐ Arthritis ☐ Pain / Numbness ☐ Energy ☐ Body fat

Circle the level of **stress** you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major **causes of stress** (e.g., changes in job, work, residence or finances, legal problems):_____

Sleep: _____ Hours of sleep / night (avg) Is your sleep disturbed ? YES / NO If yes, Reason? _____

Specifics of any symptoms (or other):	When it began	(0=None, 10= worst imaginable)
1. _____	Started: _____	0 1 2 3 4 5 6 7 8 9 10
2. _____	Started: _____	0 1 2 3 4 5 6 7 8 9 10
3. _____	Started: _____	0 1 2 3 4 5 6 7 8 9 10
4. _____	Started: _____	0 1 2 3 4 5 6 7 8 9 10

List other current health problems for which you are being treated: _____

Testing/Results done for your problems? (e.g., stool analysis, blood, urine, stool) (e.g. x-ray, MRI, CT) performed :

_____

_____

What **types of therapy have you tried** for this problem(s)?: ☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs

☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ Physical Therapy ☐ Counseling ☐ conventional drugs ☐ other

Results _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-care	☐	☐	☐	☐	Other	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED VERY COMMITED

Medical History (of yourself) ☐ **None of these**

			Other (or specifics)
☐ Neurological #1 (Circle) Depression, Anxiety, Eating disorder	☐ Neurological #2 (Circle) Parkinson's, Dementia, Epilepsy	☐ Neurological #3 (Circle) Learning disab., ADHD, Autism, Dyslexia	
☐ Alcoholism	☐ Arthritis, Osteoporosis	☐ Blood pressure problems	
☐ Asthma, Lung problem	☐ Intestinal Problems	☐ Thyroid trouble	
☐ Allergies/hay fever, Sinus	☐ Kidney or Urinary	☐ Sexually transmitted disease	
☐ Circulatory problems	☐ Liver or Gallbladder	☐ Male-specific Health problems	
☐ Environmental sensitivities	☐ Genetic disorder	☐ Female-specific Health problems	
☐ CFS, Fibromyalgia	☐ Diabetes		
☐ Autoimmune disease	☐ Heart disease, Stroke		

Family History Write any significant health condition present in 2 or more blood relatives. ☐ **None**

_____

✚Have you had an unintentional weight change of 10 pounds or more in the last three months? YES / NO (loss or gain)

✚ Do you bruise Easily? YES / NO; ✚ Do you have a History of Migraine headaches YES / NO;

✚ Did you have neck or head pain that developed over 30 minutes and had no physical cause ? YES / NO;

✚ Unrelated to pain, do you have NEW difficulty, Walking, Feeling, Seeing, Swallowing, Dizziness or Vertigo? YES / NO

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Limited body function	**Losing normal function**	No symptoms	**Minimal nerve interference**	**100% Function/Adapting**
Multiple medications	Symptoms	Nutrition inconsistent	Regular exercise	Continuous development
Poor quality of life	Drug therapy	Exercise sporadic	Good nutrition	Active participation
Potential becomes limited	Surgery	Health not a high priority	Wellness education	Wellness lifestyle

On the arrow diagram above:

1) Circle the number you think represents your health today? 2) What direction is your health currently headed? ⇦ ⇨

What are your health goals?

IMMEDIATE (must do) _____

SHORT TERM (get back to) _____

LONG TERM (want to do) _____

☐ I am taking no medications Note: If you have a list , you may leave this blank and give us the list to copy.

Medications	What for?	When Started?	Still Taking?	How often?
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly
			Yes / No	1 2 3 4 x Daily / Wkly / Mnthly

Name: DOB: / / Today's Date / /

Intake Habits

☐ Water: ____ #cups/8oz / day / wk
☐ Juices: ____ # cups/8oz / day / wk
☐ Milk: ____ # cups/8oz / day / wk
☐ Alcohol: _____
___# cups/8oz / day / wk
☐ Caffeine:
Coffee: ____ # cups/8oz /d
Tea: ____ # cups/8oz /d
Soda w/caffeine: ____ # /day
Other sources _____
☐ Other Drink: ___ # C/8oz/day/ wk
_____
☐ Smoking: _____ ____ #/day

Eating Habits (mark any/all)

☐ Skip breakfast
☐ 1 ☐ 2 ☐ 3 meal(s) per day
☐ Graze (small frequent meals)
☐ Generally eat on the run

Specific Food Restrictions

☐ dairy ☐ wheat ☐ eggs
☐ soy ☐ corn ☐ all gluten
☐ Vegetarian ☐ Vegan ☐ Keto
☐ Salt ☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ _____ Diet
Other _____

Most days I eat:

Fruits (citrus, melons, etc.) ….Y / N
Dark green or deep yellow/orange vegetables ……..Y / N
Grains (unprocessed)…..….. .Y / N
Processed grains…….... Y / N
Beans, peas, legumes …...…..Y / N
Dairy ……..Y / N
Eggs……...…….....Y / N
Meat, poultry, fish ……...…...Y / N
____ # Fast Food Meals /avg. wk

Regular Exercise (circle any)

Cycle Walk Run Jog Jump rope
Weight lift Swim Yoga Pilates ☐
Other exer_____
☐ Other exer_____
☐ Other exer_____

Exercise

☐ I do not work out
☐ I attend a gym
☐ I have home exer equip. / stab. ball
☐ 5-7 ☐ 3-4 ☐ 1-2 days per week
☐ 45+ ☐ 30-45 ☐ <30 min per workout

Supplements

Write any supplements you take or attach a list.
O I do not take supplements

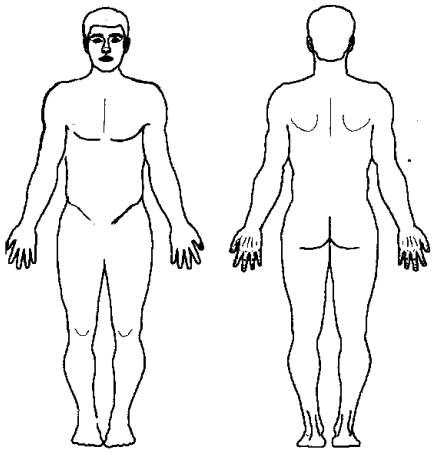
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please mark (with a number) the sites of any **surgeries, and** significant **accidents,** or **injuries – do your best**.

Then describe it in the numbered spaces below. ☐ I have had no surgeries, or only (circle) Tonsils, Wisdom teeth

You may use a number in multiple sites if the single injury involved more than one location.

When	What happened and/or What for?
Example: Jan '04	*left knee cartilage surgery after football injury .*
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____



Family Physician name _____ Office _____
(We like to send eraly-treatment reports to work together with other physicians.)

Who referred you to our office ? (mark **ALL that affected** in your decision)

☐ Friend or Relative _____ (If we know who, we'll send them a "Thank You.")
☐ Doctor or other practitioner _____
☐ Insurance ☐ Our Website ☐ PhBook (name) _____ ☐ Other _____

PATIENT'S SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE (if under 18) _____ DATE _____

Name:_____ DOB: ____ / ____ /_____