****

**1511 Tamiami Trail S., # 202**

**Venice, FL 34285**

**941-228-4688**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to check for acupuncture benefits with your insurance company?  Yes  No

If yes, please list your insurance provider and ID# below.

Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently see a pain doctor?  Yes  No If yes, who is it\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Goals:** What would you most like to achieve through your work with Dr Karen Taylor?
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. **Major Symptoms:** Please list in order of importance what symptoms are of concern to you.

(most concerning to least, along with the duration of the symptom)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Are you experiencing pain or discomfort in any area of your body? **Yes / No**

If yes, using the models to the right, please indicate the location of the discomfort by **using the symbol that best describes the feeling**

X X X = Sharp/stabbing

P P P = Pins and Needles

D D D = Dull/Aching

N N N = Numbness

***For Women:***

1. Are you pregnant now?  Yes  No  Unsure
2. Indicate the number of occurrences:

Live Births\_\_\_\_\_\_\_\_\_\_\_ Pregnancies \_\_\_\_\_\_\_\_\_\_Miscarriages \_\_\_\_\_\_\_\_\_ Abortions\_\_\_\_\_\_\_\_

1. Age:

First Period \_\_\_\_\_\_\_\_\_\_ Menopause (if applicable)\_\_\_\_\_\_\_\_\_\_\_

1. Date:

Last Pap Smear \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Last Mammogram \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

1. Any history of an abnormal Pap Smear??  Yes  No If so, what/when? \_\_\_\_\_\_\_\_\_\_\_\_
2. Is your menses cycle regular?  Yes  No
3. Average number of days of flow \_\_\_\_\_\_\_\_
4. The flow is:  Normal  Heavy  Light
5. The color is:  Normal  Dark  Purple  Light Brown  Brown
6. Do you have the following menstruation related signs/symptoms?

|  |  |  |
| --- | --- | --- |
| Difficulty with orgasm | Nausea | PMS |
| Pain with intercourse | Breast Distention | Vaginal discharge |
| Blood clots | Cramps | Heavy discharge between periods |
| Bleeding between periods | |  |

***For Men:***

1. Do you have any bothersome urinary symptoms?  Yes  No

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| Erectile dysfunction | Difficulty with orgasm | Pain or swelling of the testicles | Frequent need to urinate at night |
| Impotence/erectile dysfunction | Premature ejaculation | Feeling of coldness or numbness in genitalia | Pain/subtly of testicles |

1. Do you get up at night to urinate?  Yes  No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you sought medical intervention for these problems? If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What treatments have you tried for these problems and how successful have they been?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***Medical History***

|  |  |  |  |
| --- | --- | --- | --- |
| **Please check all that apply** | **Date Diagnosed** |  | **Date Diagnosed** |
| Diabetes | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | High Cholesterol | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| High Blood Pressure | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | Low Blood Pressure | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| Thyroid Disease | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | Seizures | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| Cancer | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | Hepatitis | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| HIV | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |

1. **Surgical History**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Family History**

Please check all that apply and state how you are related to the family member with that condition

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Mother** | **Father** | **Sibling** | **Maternal Grandparent** | **Paternal Grandparent** |
| Heart disease |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| Hypertension |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Other mental illness |  |  |  |  |  |
| Substance abuse |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |

1. **Medications/Supplements**

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Allergies (to chemicals, medications or foods):

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Nutrition**
2. Do you follow a special diet?  Yes  No If Yes, how would you describe the diet?

(for example: vegetarian, low carb, vegan, glutten free, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What do you eat on a “typical” day?
2. Breakfast \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Dinner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Snacks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Foods you tend to crave\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Foods you dislike \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **Social History**
9. How much per day do you use of the following?
10. Coffee, tea, soft drinks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Cigarettes, cigars, other tobacco \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. Other drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. Have you ever had a problem with alcohol or alcoholism?  Yes  No
15. Have you ever had a problem with dependency on other drugs?  Yes  No
16. If yes, which drug and when?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a known history of any exposure to toxic substances?  Yes  No
2. If so, please list which and when you first noticed symptoms?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the past year, how many days have been significantly affected by your health? \_\_\_\_\_\_\_\_\_\_\_\_
2. How many days did you feel generally poor? \_\_\_\_\_\_\_\_\_\_\_
3. How many times were you in the hospital? \_\_\_\_\_\_\_\_\_\_\_
4. Please describe your current exercise regimen:

Hours per week: \_\_\_\_\_\_\_\_\_\_ Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No exercise

1. How many hours of sleep do you usually get per night during the week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you awake feeling rested?  Yes  No Do you sleep well at night?  Yes  No
3. Who would you describe as your source of primary social support? What is their relationship to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Other Information**

Please list and briefly describe the most significant events in your life:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for emotional issues?  Yes  No

Have you ever considered or attempted suicide?  Yes  No

Do you have any other neurological or psychological problem?  Yes  No \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide us with any other information that you think is relevant for us to know.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health: Check all that apply**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **General** | | | **Cardiovascular** | | | **Female** | | |
| ***Past*** | ***Current*** | ***Condition*** | ***Past*** | ***Current*** | ***Condition*** | ***Past*** | ***Current*** | ***Condition*** |
|  |  | Poor appetite |  |  | High blood pressure |  |  | Frequent urinary tract infections |
|  |  | Excessive appetite |  |  | Low blood pressure |  |  | Frequent vaginal infections |
|  |  | Insomnia |  |  | Blood clots |  |  | Pain/itching of genitalia |
|  |  | Fatigue |  |  | Palpitations |  |  | Genital lesions/discharge |
|  |  | Fevers |  |  | Phlebitis |  |  | Pelvic inflammatory disease |
|  |  | Night sweats |  |  | Chest pain |  |  | Abnormal pap smear |
|  |  | Sweat easily |  |  | Irregular heart beat |  |  | Irregular menstrual periods |
|  |  | Chills |  |  | Cold hands /feet |  |  | Painful menstrual periods |
|  |  | Localized weakness |  |  | Fainting |  |  | Premenstrual syndrome |
|  |  | Poor coordination |  |  | Difficult breathing |  |  | Abnormal bleeding |
|  |  | Bleed or bruise easily |  |  | Swelling of hands/feet |  |  | Menopausal syndrome |
|  |  | Catch cold easily |  |  | Other \_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Breast lumps |
|  |  | Change in appetite |  |  |  |  |  | Hot flashes |
|  |  | Strong thirst | **Respiratory** | | |  |  | Other \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | Other\_\_\_\_\_\_\_\_\_ | ***Past*** | ***Current*** | ***Condition*** |  |  |  |
|  |  |  |  |  | Asthma |  |  |  |
| **Skin & Hair** | | |  |  | Bronchitis | **Neurological** | | |
| ***Past*** | ***Current*** | ***Condition*** |  |  | Frequent colds | ***Past*** | ***Current*** | ***Condition*** |
|  |  | Rashes |  |  | Chronic obstructive |  |  | Seizures |
|  |  | Hives |  |  | Pulmonary disease |  |  | Tremors |
|  |  | Itching |  |  | Pneumonia |  |  | Numbness/tingling of limbs |
|  |  | Eczema |  |  | Cough |  |  | Concussion |
|  |  | Pimples |  |  | Coughing blood |  |  | Pain |
|  |  | Dryness |  |  | Production of phlegm |  |  | Paralysis |
|  |  | Tumors, lumps |  |  | Other \_\_\_\_\_\_\_\_\_\_\_ |  |  | Other \_\_\_\_\_\_\_\_\_\_ |
| **Back & Neck** | | | **Gastro-Intestinal** | | | **Psychological** | | |
| ***Past*** | ***Current*** | ***Condition*** | ***Past*** | ***Current*** | ***Condition*** | ***Past*** | ***Current*** | ***Condition*** |
|  |  | Dizziness |  |  | Nausea |  |  | Depression |
|  |  | Fainting |  |  | Vomiting |  |  | Anxiety / stress |
|  |  | Neck stiffness |  |  | Diarrhea |  |  | Irritability |
|  |  | Enlarged lymph glands |  |  | Belching |  |  | Treated for emotional or |
|  |  | Headaches |  |  | Blood in stools/black |  |  | Psychological problems |
|  |  | Concussions |  |  | Stools |  |  | Other \_\_\_\_\_\_\_\_\_\_ |
|  |  | Other \_\_\_\_\_\_\_\_ |  |  | Bad Breath |  |  |  |
|  |  |  |  |  | Rectal Pain | **Infection Screening** | | |
| **Ears** | | |  |  | Hemorrhoids | ***Past*** | ***Current*** | ***Condition*** |
| ***Past*** | ***Current*** | ***Condition*** |  |  | Constipation |  |  | HIV |
|  |  | Infection |  |  | Pain or cramps |  |  | TB |
|  |  | Ringing |  |  | Indigestion |  |  | Hepatitis |
|  |  | Decreased hearing |  |  | Gall bladder disorder |  |  | Gonorrhea |
|  |  | Other \_\_\_\_\_\_\_\_ |  |  | Gas |  |  | Chlamydia |
|  |  |  |  |  | Other \_\_\_\_\_\_\_\_\_\_ |  |  | Syphilis |
| **Eyes** | | |  |  |  |  |  | Genital warts |
| ***Past*** | ***Current*** | ***Condition*** | **Genito-Urinary** | | |  |  | Herpes: oral |
|  |  | Blurred vision | ***Past*** | ***Current*** | ***Condition*** |  |  | Herpes: genital |
|  |  | Visual changes |  |  | Kidney stones |  |  |  |
|  |  | Poor night vision |  |  | Pain or urination | **Muscular-Skeletal** | | |
|  |  | Spots |  |  | Frequent urination | ***Past*** | ***Current*** | ***Condition*** |
|  |  | Cataracts |  |  | Blood in urine |  |  | Stiff neck / shoulders |
|  |  | Glasses/contacts |  |  | Urgency to urinate |  |  | Low back pain |
|  |  | Eye inflammation |  |  | Unable to hold urine |  |  | Back pain |
|  |  | Other \_\_\_\_\_\_\_\_\_ |  |  | Other \_\_\_\_\_\_\_\_\_\_ |  |  | Muscle spasm, twitching, cramps |
|  |  |  |  |  |  |  |  | Sore, cold or weak knees |
| **Nose, Throat, Mouth** | | | **Male** | | |  |  |  |  |  |  | Joint pain |
| ***Past*** | ***Current*** | ***Condition*** | ***Past*** | ***Current*** | ***Condition*** |  |  |  |
|  |  | Nose bleeds |  |  | Pain / itching genitals |  |  |  |
|  |  | Sinus infections |  |  | Genital lesions / discharge |  |  |  |
|  |  | Hay fever or allergies |  |  | Impotence |  |  |  |
|  |  | Recurring sore throats |  |  | Weak urinary stream |  |  |  |
|  |  | Grinding teeth |  |  | Lumps in testicles |  |  |  |
|  |  | Difficulty swallowing |  |  | Other \_\_\_\_\_\_\_\_\_\_ |  |  |  |