****

**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 \_\_\_\_\_\_\_\_\_\_ |  |  |  |