

**Please bring this completed form along with the
Contact Information and Freedom Act forms with you to your appointment.**

Date of appointment: _____

Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Please list the health concerns that brought you in today, in order of importance to you:

Concern	Date Started	Current Treatment
1.		
2.		
3.		

Please list the medications, supplements and the doses for each that you are currently taking:

Medication	Dose	Supplement	Dose
1. _____		1. _____	
2. _____		2. _____	
3. _____		3. _____	
4. _____		4. _____	
5. _____		5. _____	

Do you have a severe or life threatening allergy to medication or anything else? Yes No
Please list: _____

Do you follow any specific dietary guidelines?
 Vegetarian Vegan Food allergy: _____
 Other: _____

Occupation: _____ How long have you done this work? _____
 Do you enjoy it? _____ Do you consider your work stressful? _____

Hobbies: _____

Are you: Single Significant Other Married Separated Divorced

Do you have children? If so, please list their list their ages: _____

Who do you live with (please include pets)? _____

Height: _____ Weight: _____ Weight 1 year ago: _____

Please answer the following questions about your past health history:

Birth and infancy: Were you _____ Full-term pregnancy _____ Premature _____ Vaginal delivery
 _____ C-section _____ Breast-fed _____ Vaccinated _____ Unknown

Birth weight, if known: _____

Have you ever had any of the following common health conditions?

Condition	Approx. age	On-going? Y/ N		Condition	Approx Age	On-going? Y/ N
Tonsillitis				Eczema		
Frequent ear infections				Acne		
Chicken Pox				ADD/ADHD		
Measles				Autism		
Mumps				Lyme's Disease		
Mono				Depression		
Headaches or migraines				Chronic stomach issues (reflux, constipation, diarrhea)		
Obesity				Urinary tract infections		
Chronic fatigue				Other:		

Females:

Age of 1st menses: _____
 Have you ever had an abnormal PAP? _____ No _____ Yes: When? _____
 Number of Pregnancies: _____ Number of live births: _____
 Are you using birth control? _____ No _____ Yes: What type? _____

If you are still having periods:

Average number of days of bleeding: _____ Average number of days between periods: _____
 Bleeding is: _____ Light _____ Medium _____ Heavy (clots) _____ Spotting between periods
 Symptoms: _____ Pain _____ Cravings _____ Mood swings _____ Breast tenderness

Have you been diagnosed with: _____ PCOS _____ Fibroids _____ Endometriosis
 _____ Frequent yeast or other vaginal infections _____ Infertility _____ Fibrocystic breasts

If you are no longer having periods:

Have you had a hysterectomy? _____ No _____ Yes: When? _____
 Do you have: _____ Hot Flashes _____ Dry skin _____ Vaginal dryness
 _____ Incontinence _____ Memory loss _____ Changes in libido
 Other: _____
 Are you using hormone replacement therapy? _____ No _____ Yes: Type: _____

Males:

Are you having any issues with urination, including: _____ Urgency _____ Increased Frequency

Please list any other major illnesses, current diagnoses, hospitalizations or injuries:

Do you or a family member have a history of any of the following?

	You	Mother	Father	Sister	Brother	Grandparent
Alzheimer's						
Anemia						
Allergies or Asthma						
Arthritis						
Autoimmune Disease, Ex: Lupus, Rheumatoid Arthritis, Celiac's...						
Bowel disease, Ex.: Ulcerative Colitis, Crohn's, Diverticulitis						
Cancer, list type						
Diabetes						
Heart Disease						
High Cholesterol						
High Blood Pressure						
Mental Illness						
Osteoporosis						
Stroke						
Thyroid Disease						

Please mark any that apply and fill in any corresponding details:

Exercise _____ hours per week Activities: _____
 Smoke or use tobacco
 Alcohol intake _____ drinks per week I am recovering from alcohol abuse.
 Recreational drug use _____ I am recovering from substance abuse.
 Major life change in the past year: _____

What time do you go to bed (a range, such as between 10-11pm is fine)?

Workdays: _____ Weekends or non-work days: _____

What time do you wake up?

Workdays: _____ Weekends or non-work days: _____

Do you have trouble falling asleep? Have trouble staying asleep? Wake still tired?

What is your goal for treatment today? _____

What questions do you want to make sure you ask? _____

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