NAME_____

DATE OF BIRTH_____

HEIGHT_____

WEIGHT_____ Are you gaining, losing, or stable? (Please circle)

What is your optimal weight?_____

ALLERGIES_____

PLEASE LIST ALL DOCTORS THAT YOU SEE_____

_____

WHAT ARE YOU SEEKING TREATMENT FOR?_____

_____

PLEASE LIST ALL CURRENT HEALTH PROBLEMS_____

_____

_____

PLEASE LIST ALL PAST MEDICAL PROBLEMS_____

_____

_____

PLEASE LIST ANY AND ALL SURGERGIES WITH DATES, INCLUDE DENTAL AND COLONSCOPY_____

_____

HAVE YOU HAD ANY CAR ACCIDENTS OR OTHER TRAUMA? Please explain._____

_____

IMMUNIZATIONS/FLU SHOTS Please list all "shots" you have had_____

_____

MEDICATIONS Please list all medications and supplements that you take_____

_____

_____

_____

_____

FAMILY HISTORY-For each member of the family please indicate their present state of health and any illnesses they have had in the past.

Mother_____

Father_____

Brothers/Sisters_____

Spouse_____

Children_____

Other relatives with significant illnesses_____

WHAT IS YOUR STRESS LEVEL?_____

WHAT IS YOUR ENERGY LEVEL?_____

WHAT KIND OF SOCIAL SUPPORT SYSTEM DO YOU HAVE?_____

DO YOU HAVE ANY PETS? Please list_____

DO YOU SMOKE? How much/how long_____

DO YOU DRINK ALCOHOL? How much/how often_____

DO YOU CONSUME CAFFEINE? How much/how often_____

DO YOU DRINK SODA? How much/how often_____

DO YOU HAVE ANY CRAVINGS? Please list_____

DO YOU EXERCISE? How much/how often_____

HOW MANY HOURS A WEEK DO YOU WORK?_____

WHAT DO YOU DO FOR FUN?_____

HAVE YOU TRAVELED OUTSIDE THE UNITED STATES? When/Where_____

_____

HAVE YOU EVER HAD ANY INFECTIONS OR TICK BITES? When_____

_____

DO YOU GET COLDS/FLU OFTEN?_____

HOW OFTEN HAVE YOU TAKEN ANTIBIOTICS?_____

DO YOU TEND TO FEEL COLD OR WARM?_____

DO YOU SWEAT?_____

DO YOU FEEL MORE ENERGETIC IN THE MORNING OR AT NIGHT?_____

SLEEP

What time do you go to bed?_____, How long does it take to fall asleep?_____

How is the quality of your sleep?_____, Do you dream?_____

Do you wake up during the night?_____, What time?_____, Do you have trouble going back to sleep?_____, What time do you wake up in the morning?_____

Naturally or to an alarm?_____, Do you feel refreshed or tired?_____

Do you take naps during the day?_____, What time/how long_____

IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS PLEASE CIRCLE AND EXPLAIN THEN INCLUDE ANYTHING ELSE YOU THINK I SHOULD KNOW.

NEURO/EMOTIONAL

Seizures/Convulsions Head injury/Concussion Dizziness Loss of balance Fainting Shaking Trembling Poor coordination Nerve problem Numbness/Tingling

Optimist Pessimist Annoyed easily Lose temper often Anxious Nervous, Shy Sensitive Worried Fearful Sad Lonely Depressed Hard to concentrate remember make decisions relax

Desired/Sought counseling

Explain_____

_____

HEADACHES?_____Type_____Frequency_____

Location_____Triggers_____

_____

EYE PROBLEMS? Wear glasses Blurry vision Dry Watery Tired Strabismus Astigmatism Cataracts Glaucoma Macular degeneration

Explain_____

EARS/HEARING PROBLEMS?_____ Excess wax Tinnitus/High pitch Low pitch

Explain_____

NOSE PROBLEMS?_____ Nosebleeds Dry Runny Congested Post nasal drip

Explain_____

THROAT PROBLEMS?_____ Hoarse Difficult swallowing Cough Dry Phlegm

Explain_____

TEETH PROBLEMS?_____ Gums bleed Teeth grinding Silver fillings Caps/bridge TMJ

Explain_____

MOUTH PROBLEMS?_____ Bad breath Cold sores Canker sores Swelling Sore tongue Taste changes

Explain_____

_____

SKIN PROBLEMS?_____ Sensitive Dry Oily Rashes Hives Acne Ulcers Bruise easily Dandruff Hair loss

Explain_____

RESPIRATORY PROBLEMS?_____ Shortness of breath Wheezing Chest tightness Cough

Explain_____

HEART PROBLEMS? _____ Chest pain Heart murmur Feeling your heart beating Skipped beats Cold hands/feet Swelling feet/legs What is your blood pressure_____

Explain_____

BONE?MUSCLE PROBLEMS?_____ Broken Swollen Pain Stiff Tense Tired Heavy Weak Spasms Burning Achy Sharp Dull Constant Intermittent Worse in morning/evening Wakes you up at night Neck Upper back Mid back Lower back Ribs Shoulder Arm Elbow Wrist Hand Fingers Hip Leg Knee Ankle Foot Toes Right side Left side Both
Explain_____

DIGESTIVE PROBLEMS?_____ Nausea Acid reflux Indigestion Belching Hiatal hernia Stomach pain Abdominal pain Bloating Gas Noisy gurgling Diarrhea Constipation Dark stools Hemorrhoids Bleeding
Explain_____
Do you regularly use antacids or laxatives?_____How often?_____
How often do you have a bowel movement?_____
Do you feel thirsty?_____ How much water do you drink every day?_____
How is your appetite?_____
Please list foods that you eat on a typical day
Breakfast_____
Lunch_____
Dinner_____
Snacks_____

URINARY PROBLEMS?_____ UTI Frequency Urgency Burning Stress incontinence Difficulty starting urine stream Weak urine stream Cloudy urine Blood in urine Pain/Pressure Waking up at night to urinate
Explain_____

ENDOCRINE PROBLEMS?_____ Thyroid Adrenal gland Hormones
Explain_____

REPRODUCTIVE
Women
How old were you when your periods started?_____ Are/were they regular/irregular_____ Your period comes every _____ days and lasts for _____ days
Is your flow light moderate heavy_____ do you have PMS_____ Cramps_____
Pass clots_____ How many times have you been pregnant_____ How many deliveries_____
Vaginal or C-section_____ Epidural_____ Miscarriages_____Abortions_____
Have your periods stopped_____Hot flashes_____ Night sweats_____Other_____
Vaginal discharge_____Yeast infections_____ Last PAP/Exam_____
Breast tenderness_____Mammogram_____ Monthly breast self exam_____
Libido/sexual function issues_____Pain_____
Anything else_____
Men
Prostrate issues Testicular pain Do you do a monthly testicle self exam_____ PSA level_____
Libido/sexual function issues_____
Anything else_____

WHAT WOULD YOU LIKE TO CHANGE THE MOST ABOUT YOUR HEALTH
PHYSICALLY EMOTIONALLY
SPIRITUALLY_____
_____
_____

Thank you.
Cheri Suzuki