**NATUROPATHIC MEDICINE INTAKE FORM**

*To optimize time during your visit, please return this form no later than 3 business days prior to your appointment.*

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician (PCP):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please list your major health concern(s):***

| Concern: | When did it start? |
| --- | --- |
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Other Doctors, Chiropractors, Acupuncturists and Physical Therapists you see and for what?

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4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please rate your motivation to affect change in your health (1 = unmotivated, 10 = highly motivated)

1 2 3 4 5 6 7 8 9 10

***Prescription and Over-the-Counter Medications currently taking:***

| Name of Medication | Dose/Frequency | Date Started | Condition Being Addressed |
| --- | --- | --- | --- |
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***Past Medications:***

| Name of Medication | Dose/Frequency | Date Started | Condition Being Addressed |
| --- | --- | --- | --- |
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***Nutritional Supplements (include vitamins, medicinal herbs and homeopathic remedies):***

| Name of Supplement | Dose/Frequency | Date Started | Condition Being Addressed |
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Are there any concerning adverse effects from any of the above?

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**Past Medical History:**

Your Birth History (c-section, prolonged labor, forceps delivery, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been prescribed antibiotics?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which Childhood Illness have you had? (circle)

Chicken Pox Measles Mumps Whooping Cough

Rheumatic Fever Scarlet Fever Roseola Rubella (German Measles) Polio Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Illness (circle):

Heart Disease High Blood Pressure Stroke Seizures

Diabetes Thyroid Disease Depression Anxiety

Asthma Hepatitis A/B/C

Cancer(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autoimmune Disease(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other major illnesses that have been diagnosed or suspected?

Illness When? How was it diagnosed? (lab, imaging, symptoms)

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Injury/Trauma/Accidents:

What was injured? When? Treatment?

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Surgeries/Hospitalizations:

Reason(s)? When? Treatment?

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Do you have Allergies? What symptoms do you experience?

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drugs/Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental/Chemical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seasonal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do any of these issues affect your daily activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Physical Exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any abnormal findings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last Lab Work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any abnormal findings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you know your Blood Type? \_\_A + / - \_\_AB + / - \_\_B + / - \_\_O + / - \_\_Don’t know

**Family History:**

Please list ages and health conditions (including illness). If deceased, age of passing and from what?

*Maternal*

Mother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandfather:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandmother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Paternal*

Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandfather:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandmother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Review of Symptoms:**

**Circle** if the symptom has occurred in the last year. Please place a **check** **mark** if the symptom occurred in the *past*, **1** for *current* but not often, **2** for *current* but occasional, **3** for *current* and often.

| **General** | Weight gain  Weight loss  Weight gain (20lbs)  Weight loss (20lbs)  History of dieting | Chronic Fatigue  Afternoon Fatigue  Weakness  Excessive Thirst | Spontaneous sweating  Night sweats  Fever/Chills Anemia | Heat intolerance  Cold intolerance  Cold hands/feet  Others: |
| --- | --- | --- | --- | --- |
| **Skin** | Dry skin  Itchy Skin  Rashes  Hives  Bruise easily | Acne  Eczema  Psoriasis  Shingles  Fungal Rash/ringworm | Athlete’s Foot  Nail Fungus  Moles  Varicose veins  Bumpy skin back of arms | Any change to nails  Any change to skin color  Any change to moles  Others: |
| **Head** | Headaches  Migraines | Dizziness  Vertigo | Trauma  Hair Loss | Seizures  Other: |
| **Eyes**    Last Eye Exam:    \_\_\_\_\_\_\_\_\_\_ | Dry eyes  Watery eyes  Itchy eyes  Eye pain  Red eyes  Eye discharge | Blurred vision  Double vision  Sensitive to light  Poor night vision | Styes  Cataracts  Vision loss  Other: | Vision correction:  Nearsighted  Farsighted    Contacts  Glasses  Laser |
| **Ears** | Ear pain  Itchy ears  Waxy ears | Discharge from ears  Ringing in ears  Hearing loss | Ear infections  Ear infections as child | Hearing aids  Other: |
| **Nose & Sinuses** | Itchy nose  Discharge from nose  Phlegm | Hay fever/Allergies  Post nasal drip  Nosebleeds  Loss of smell | Breathes through mouth  Snores | CPAP use  Other: |
| **Mouth & Throat**    Last Dental  Exam:  \_\_\_\_\_\_\_\_\_\_ | Dry mouth  Itchy mouth/lips  Sores on mouth/lips  Bad breath  # of mercury amalgams\_\_\_\_\_\_\_\_\_ | Frequent sore throat  Difficulty swallowing  Loss of taste  Hoarseness | Dentures  Inflamed/bleeding gums  Teeth sensitivity  Braces | Jaw clicking  TMJ  Other: |
| **Neck** | Neck pain | Swollen glands | Trauma | Other: |
| **Respiratory** | Shortness of breath  Wheezing  Pain with breath  Coughing up blood Persistent cough | Asthma  Bronchitis  Pneumonia  Out of breath with exertion | Exposure to:   * Chemicals * Solvents * Particulate | Tuberculosis  Other: |
| **Cardiovascular**    Last EKG:  \_\_\_\_\_\_\_\_\_\_ | High blood pressure  Low blood pressure  High Cholesterol  Chest pain  Heaviness in legs  Bleeding issues  Stroke | Heart races  Palpitations  Chest tightness  Difficulty breathing at night  Swelling in ankles | Cold hands/feet  Purple fingers/lips  Heart murmur  Dizzy on standing  Exhaustion with mild exertion | Clots  Varicose veins  Spider veins  Calf-pain, night  Calf-pain, walking  Other: |
| **Gastrointestinal (upper)**    Last Endoscopy:  \_\_\_\_\_\_\_\_\_\_ | Poor appetite  Excessive appetite/thirst  Changes in appetite  Trouble swallowing  Stomach pain | Nausea  Vomiting  Burping  Belching  Heartburn  H. pylori  Ulcers | Intolerance to foods: (list food and reactions) | Fatigue after eating  Anal itching  Liver disease  Gallbladder disease  Treated for parasites  Other: |
| **Gastrointestinal (lower)**    Last Colonoscopy:  \_\_\_\_\_\_\_\_\_\_    Last Rectal Exam:  \_\_\_\_\_\_\_\_\_\_\_\_ | Abdominal pain  Abdominal bloating  Gas/flatulence    History of abdominal/pelvic surgery: | Constipation <1 stool a day  Painful stool  Hemorrhoids  Blood in stools  Blood on stools | Stool hard to pass  Foul smelling  Loose stools  Frequent stools  > 3 day  Undigested food in stools | Stool shape:   * One piece * Little pellets * Breaks up * Other:   Color:   * Yellow * Green * Brown * Black * Other: |
| **Kidney/Urinary** | Frequent urination  Urinate <3x day  Can’t hold urine  Urination with cough or sneeze | Kidney infections  Bladder infections  Urination at night  Pain/burning with urination | Dripping after urinating  Bed-wetting    Other: | Color:   * Light yellow * Dark yellow * Red urine * Cloudy * Strong smelling |
| **Musculoskeletal** | Pain in:  Arms Shoulders  Neck Hands  Upper back  Lower back  Hips Legs  Knees Feet | Painful bones  Tight shoulders  Pain on muscles  Swollen knees/elbows  Spasms/cramps  Morning stiffness  Tendonitis  # Broken Bones: | Chronic pain  Loss of height  Osteoporosis  Unable to sit straight  Activities limited due to pain Herniated/  bulging disc | Arthritis:   * Rheumatoid * Osteo * Psoriatic * Other:   DEXA scan? Y / N  When?  Results? |
| **Neurologic** | Fainting  Dizziness/Vertigo  Numbness/tingling  Where?  Trembling hands | Poor concentration  Memory loss   * Long term * Short term   Lack of alertness | Loss of grip  Loss of muscle tone  Muscle weakness  Head heavy  Heavy extremities | Head trauma    Other: |
| **Endocrine** | Hypothyroid   * Surgical * Hashimoto’s * Unknown cause   Hyperthyroid | Hypoglycemia  Hyperglycemia   * DM1 * DM2 * Medications Y / N | Cold hands/feet  Cold intolerance  Excessive thirst  Fatigue  Poor appetite  Excessive Hunger | Unexplained weight gain/loss    Other: |
| **Immune** | Slow wound healing  Reactions to vaccines  Cancer  Mononucleosis Chronic infections | Chronic fatigue syndrome  Autoimmune disorder | Chronically swollen glands  Chicken pox  Shingles | Frequent colds/flu  Herpes  Warts  Other: |
| **Men Only**    PSA test: \_\_\_\_\_\_\_    Prostate exam: \_\_\_\_\_\_\_\_ | Sense of full bladder  Difficulty urinating  Pain with urination  Wake >1x to urinate  Dripping after urination  Strain with urination  Discharge from penis  Sore on penis | History of STI:  Y / N  \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Premature ejaculation  Erectile dysfunction  Sexual difficulties  Libido:  1 2 3 4 5 | Testicular pain  Testicular lump  Testicular monthly exam  Y / N  History of prostatitis  Pain in genitals  Hernia | Sexually active: Y/N  Gender you are sexually active with? Men/ Women/Both  Type of birth/STI control?   * Condoms * Vasectomy * Other: |
| **Women Only** | Monthly Breast  self exam: Y / N  Fibrous breast  Breast fed a child  Implants  Reduction  Nipple discharge | History of mammogram  Abnormal mammogram  +PAP history  Cryo  LEEP | Menopause  Age: \_\_\_\_\_  Years ago:\_\_\_\_\_\_  Hot flashes  Night sweats  Moodiness  Brain fog  Vaginal dryness | Hormone replacement   * Standard * Natural * Herbal   Other: |
| **Women Only** | Menses  Age of first:­­\_\_\_\_\_\_\_\_  Length of cycle: \_\_\_\_  Date of last menses:­  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Days bleed:­­­\_\_\_\_\_\_\_\_  Heaviest flow day:­­­\_\_\_  Heavy days # of pads/tampons:\_\_\_\_\_\_  Clots?  Cramp Intensity:  1 2 3 4 5  Medication: Y / N /Occ  Hysterectomy  Fibroids  Cystic Pain | Sexually active: Y/N  # Pregnancies:  # Live births:  Gender you are sexually active with? Men/ Women/Both  Birth control?   * Birth control pills * IUD Cu+/ Hormone * NFP * Implant * Depo shot * Condoms * Vasectomy * Other: | Spotting between menses  Missed period  Irregular menses  Difficulty conceiving  PMS symptoms:   * Irritability * Moodiness * Crave sweet * Crave salt * Bloating * Breast tenderness * Fatigue | Vaginal:   * Itching * Discharge * Odor * Dryness     Infections:   * Yeast * Bacterial * Viral     History of STI:  Y / N  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Libido:  1 2 3 4 5 |
| **Sleep** | Difficulty falling  Difficulty staying  Wake refreshed Wake tired | Wake catching breath  Snore | Hours of sleep\_\_\_\_\_\_\_\_  Hours sleep needed \_\_\_\_\_\_ | Sleep apnea  treatment: Y / N  Other: |
| **Emotional & Mental** | Unexplained crying  Loss of interest  Boredom  Restless  Panic attacks  Aggression  Socially withdrawn  Indecisiveness | Self-blame  Excessive guilt  Irritability  Worry  Loss of confidence/  self-esteem  Thoughts of suicide | Inability to concentrate  Anxiety  Overly concerned with social encounters  Disturbance in planning or execution of plan | Memory impaired   * Recall words * Learn new tasks   Unable to recognize or identify objects  Other: |
| **Exercise** | Never  0-2 x week  2-5 x week  5 + x week | Intense  Moderate  Easy going | Bike Walk  Swim Hike  Run Gym  Weights  Sports: | Other: |
| **Lifestyle** | Spiritual participation  Yoga  Tai chi  Chi Kung  Meditation  Other: | Knitting  Crocheting  Quilting  Painting  Drawing  Photography  Reading  Other: | Single/In relationship/  Engaged/  Married/  Separated/  Divorced  # of children:  # of children living with you \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Daily/Weekly/  Monthly use of:  Alcohol \_\_\_\_\_\_\_\_\_\_\_\_  Marijuana \_\_\_\_\_\_\_\_\_\_\_\_  Tobacco \_\_\_\_\_\_\_\_\_\_\_\_  How many years? \_\_\_\_\_\_\_\_\_\_\_\_  Other: |

Rate your Stress Level (1 = low, 10 = very high):

1 2 3 4 5 6 7 8 9 10

Circle and rate the contributors:

Health:\_\_\_\_\_\_ Work/School:\_\_\_\_\_\_\_ Money:\_\_\_\_\_\_ Kids:\_\_\_\_\_\_ Marriage:\_\_\_\_\_\_ Parents:\_\_\_\_\_\_ Home:\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you relax?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Environment:**

Who lives with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your family relationships?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How would you describe the emotional climate of your home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you feel safe in your home? □ Yes □ No

Have you ever been a victim of violence? □ Yes □ No

Are you afraid that someone might hurt you? □ Yes □ No

Are you afraid that you might hurt yourself or others? □ Yes □ No

**Dietary History:**

Height:\_\_\_\_\_\_\_\_\_ Current Weight:\_\_\_\_\_\_\_\_\_

Do you have any dietary restrictions?

\_\_Not Restricted \_\_Vegetarian \_\_Vegan \_\_Religious \_\_Other Restrictions

If restricted, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe a typical day’s diet:

Breakfast:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you usually buy your food?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you often thirsty?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of water you drink each day? \_\_\_\_\_\_\_\_\_ oz

Do you regularly consume any of the following (please include what and approximate amount)?

Coffee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeinated Beverages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Beverages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Processed/Refined Foods:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any foods that you crave regardless of their nutritional value including chocolate, sweets, sour, salt, bread, rich/fatty food:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you satisfied with your diet the way it is now? Why or why not?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Social History:**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you enjoy your work? Or, is it a job that you feel you must do in order to make a living?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How would you describe your relationship with your co-workers?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Are your home and/or work environments well ventilated? □ Yes □ No

Are your home and/or work environments excessively: □ Damp □ Dry

Are you sensitive to fragrances or environmental chemicals? □ Yes □ No

Are you sensitive to molds? □ Yes □ No

Is there mold exposure at home or work? □ Yes □ No

Have you ever been exposed to toxic chemicals, solvents or other possible toxins?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

In your everyday life, your present faith/spiritual practices are (1 = least important, 10 = very important)

1 2 3 4 5 6 7 8 9 10

Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do that brings you joy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

###### What will you do when you are well that you are not doing now?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else we should know?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for taking the time to provide this information so that we may provide you with more effective care.*