

Are you under the care of any specialists? **Yes/No** _____
 (Name) (Specialty) (City)

Are you receiving other health care? Yes/No: _____

Please list your major health concerns in order of importance

Complaint	Since	Possible Cause(s)

What medications/supplements are you currently taking (prescription/over-the-counter/supplements/vitamins/mineral etc)?

Medication/Supplement	Since	Adverse Effects

List all surgeries you have had:

Procedure	Year	Complications?

List any major injuries you have sustained:

Injury	Year	Long Term Effects

Which of the following conditions have you had? (Check all that apply)

<input type="checkbox"/> Abscesses	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes Genitalia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parasites	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Amnesia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Typhoid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Venereal Warts
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Sunstroke	<input type="checkbox"/> Worms
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Miscarriage		<input type="checkbox"/> Stroke	<input type="checkbox"/> Yellow Fever

Which of the following do you currently use? (amount, how often, how much, how long)

Alcohol _____	Tobacco _____
Hormones _____	Coffee _____
Cortisone _____	Laxatives _____
Sedatives _____	Antacids _____
Recreational Drugs _____	

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home, or travelling? **Yes/No**

If Yes, please explain: _____

Which of the following ailments listed, or any others, have affected your parents or siblings

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Strep Throat
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Gout	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Skin Diseases	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure			

Do you have any other medical conditions? _____

The general state of your health is: _____ Excellent
_____ Good
_____ Average
_____ Fair
_____ Poor

On average, describe your energy level (10 = highest & 1 = lowest) _____
When during the day is energy the best? _____ and worst _____

Do you exercise? **Yes/No** What forms? _____
How often? _____

What are your interests or hobbies? _____

How Often? _____

How many meals do you generally eat each day? _____

Who cooks and prepares your food? _____

Is it comfortable to chew your food well? **Yes/No**

List the primary foods included in your diet for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

List the foods you exclude from your diet: _____

Why are these foods excluded? _____

List any of the foods that you crave (eg: chocolate, sweets, salty, sour, breads, rich/fatty or spicy foods): _____

Have you had a bad reaction to any foods? _____

Are you satisfied with your diet as it is now? **Yes/No**

Do you tend to be thirsty: **Yes/No**

How much WATER do you drink each day: _____

Do you prefer beverages: _____ Hot _____ Cold _____ Room Temperature

How many times do you urinate each day? _____

Do you get up in the night to urinate? **Yes/No**

How often do you have a bowel movement? _____

On average, how many hours sleep do you get per night? _____ hrs

Do you sleep well? **Yes/No**

Women Only

Age of first period: _____

Number of pregnancies: _____

Number of children: _____

Length of Cycle: _____

Length of Menses (period): _____

Have you had any adverse effects from a vaccination? **Yes/No**

If Yes, which one(s): _____

Have your weight changed lately? **Lost/Gained/No Change**

How many pounds? _____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (**Yes/No**)

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

5. _____ Date: _____

Is there anything else I need to know about you personally, about your health condition, or about the circumstances relating to you or your condition?