**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?

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 gainWeight lossWeight gain (20lbs)Weight loss (20lbs)History of dieting | Chronic FatigueAfternoon FatigueWeaknessExcessive Thirst | Spontaneous sweatingNight sweatsFever/Chills Anemia | Heat intoleranceCold intoleranceCold hands/feetOthers: |
| --- | --- | --- | --- | --- |
| **Skin** | Dry skinItchy SkinRashesHivesBruise easily | AcneEczemaPsoriasisShinglesFungal Rash/ringworm | Athlete’s FootNail FungusMolesVaricose veinsBumpy skin back of arms | Any change to nailsAny change to skin colorAny change to molesOthers: |
| **Head** | HeadachesMigraines | DizzinessVertigo | TraumaHair Loss | SeizuresOther: |
| **Eyes** Last Eye Exam: \_\_\_\_\_\_\_\_\_\_ | Dry eyesWatery eyesItchy eyesEye painRed eyesEye discharge | Blurred visionDouble visionSensitive to lightPoor night vision | StyesCataractsVision lossOther: | Vision correction:NearsightedFarsighted ContactsGlassesLaser |
| **Ears** | Ear painItchy earsWaxy ears | Discharge from earsRinging in earsHearing loss | Ear infectionsEar infections as child | Hearing aidsOther:  |
| **Nose & Sinuses** | Itchy noseDischarge from nosePhlegm | Hay fever/AllergiesPost nasal dripNosebleedsLoss of smell | Breathes through mouthSnores | CPAP useOther: |
| **Mouth & Throat** Last Dental Exam:\_\_\_\_\_\_\_\_\_\_ | Dry mouthItchy mouth/lipsSores on mouth/lipsBad breath# of mercury amalgams\_\_\_\_\_\_\_\_\_ | Frequent sore throatDifficulty swallowingLoss of tasteHoarseness | DenturesInflamed/bleeding gumsTeeth sensitivityBraces | Jaw clickingTMJOther: |
| **Neck** | Neck pain | Swollen glands | Trauma | Other: |
| **Respiratory** | Shortness of breathWheezingPain with breathCoughing up blood Persistent cough | AsthmaBronchitisPneumoniaOut of breath with exertion  | Exposure to:* Chemicals
* Solvents
* Particulate
 | TuberculosisOther: |
| **Cardiovascular** Last EKG:\_\_\_\_\_\_\_\_\_\_  | High blood pressureLow blood pressureHigh CholesterolChest painHeaviness in legsBleeding issues Stroke | Heart racesPalpitationsChest tightnessDifficulty breathing at nightSwelling in ankles | Cold hands/feetPurple fingers/lipsHeart murmurDizzy on standingExhaustion with mild exertion | ClotsVaricose veinsSpider veinsCalf-pain, nightCalf-pain, walkingOther: |
| **Gastrointestinal (upper)** Last Endoscopy: \_\_\_\_\_\_\_\_\_\_ | Poor appetiteExcessive appetite/thirstChanges in appetiteTrouble swallowingStomach pain | NauseaVomitingBurpingBelchingHeartburnH. pyloriUlcers | Intolerance to foods: (list food and reactions) | Fatigue after eatingAnal itchingLiver diseaseGallbladder diseaseTreated for parasitesOther: |
| **Gastrointestinal (lower)**  Last Colonoscopy: \_\_\_\_\_\_\_\_\_\_  Last Rectal Exam:\_\_\_\_\_\_\_\_\_\_\_\_ | Abdominal painAbdominal bloatingGas/flatulence History of abdominal/pelvic surgery: | Constipation <1 stool a dayPainful stoolHemorrhoidsBlood in stoolsBlood on stools | Stool hard to passFoul smelling Loose stoolsFrequent stools > 3 dayUndigested food in stools | Stool shape:* One piece
* Little pellets
* Breaks up
* Other:

Color:* Yellow
* Green
* Brown
* Black
* Other:
 |
| **Kidney/Urinary** | Frequent urinationUrinate <3x dayCan’t hold urineUrination with cough or sneeze | Kidney infectionsBladder infectionsUrination at nightPain/burning with urination | Dripping after urinatingBed-wetting Other:   | Color:* Light yellow
* Dark yellow
* Red urine
* Cloudy
* Strong smelling
 |
| **Musculoskeletal** | Pain in:Arms ShouldersNeck HandsUpper backLower backHips LegsKnees Feet | Painful bonesTight shouldersPain on musclesSwollen knees/elbowsSpasms/crampsMorning stiffnessTendonitis # Broken Bones: | Chronic painLoss of heightOsteoporosisUnable to sit straightActivities limited due to pain Herniated/bulging disc | Arthritis:* Rheumatoid
* Osteo
* Psoriatic
* Other:

DEXA scan? Y / NWhen? Results? |
| **Neurologic** | FaintingDizziness/VertigoNumbness/tinglingWhere?Trembling hands | Poor concentrationMemory loss* Long term
* Short term

Lack of alertness | Loss of gripLoss of muscle toneMuscle weaknessHead heavyHeavy extremities | Head trauma Other: |
| **Endocrine** | Hypothyroid* Surgical
* Hashimoto’s
* Unknown cause

Hyperthyroid | HypoglycemiaHyperglycemia* DM1
* DM2
* Medications Y / N
 | Cold hands/feetCold intoleranceExcessive thirstFatiguePoor appetiteExcessive Hunger | Unexplained weight gain/loss Other:   |
| **Immune** | Slow wound healingReactions to vaccinesCancerMononucleosis Chronic infections | Chronic fatigue syndromeAutoimmune disorder  | Chronically swollen glandsChicken poxShingles | Frequent colds/fluHerpesWartsOther: |
| **Men Only** PSA test: \_\_\_\_\_\_\_ Prostate exam: \_\_\_\_\_\_\_\_ | Sense of full bladderDifficulty urinatingPain with urinationWake >1x to urinateDripping after urinationStrain with urinationDischarge from penisSore on penis | History of STI: Y / N\_\_\_\_\_\_\_\_\_\_\_\_\_\_Premature ejaculationErectile dysfunctionSexual difficultiesLibido: 1 2 3 4 5 | Testicular painTesticular lumpTesticular monthly exam Y / NHistory of prostatitisPain in genitalsHernia | Sexually active: Y/NGender you are sexually active with? Men/ Women/Both Type of birth/STI control?* Condoms
* Vasectomy
* Other:
 |
| **Women Only** | Monthly Breastself exam: Y / NFibrous breastBreast fed a childImplantsReductionNipple discharge | History of mammogramAbnormal mammogram+PAP historyCryoLEEP | MenopauseAge: \_\_\_\_\_ Years ago:\_\_\_\_\_\_Hot flashesNight sweatsMoodinessBrain fogVaginal dryness | Hormone replacement* Standard
* Natural
* Herbal

Other: |
| **Women Only** | MensesAge 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 5Medication: Y / N /OccHysterectomyFibroidsCystic 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 mensesMissed periodIrregular mensesDifficulty conceivingPMS 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 fallingDifficulty stayingWake refreshed Wake tired | Wake catching breathSnore | Hours of sleep\_\_\_\_\_\_\_\_Hours sleep needed \_\_\_\_\_\_ | Sleep apneatreatment: Y / NOther: |
| **Emotional & Mental** | Unexplained cryingLoss of interestBoredomRestlessPanic attacksAggressionSocially withdrawnIndecisiveness | Self-blameExcessive guiltIrritabilityWorryLoss of confidence/self-esteem Thoughts of suicide | Inability to concentrateAnxietyOverly concerned with social encountersDisturbance in planning or execution of plan | Memory impaired* Recall words
* Learn new tasks

Unable to recognize or identify objectsOther: |
| **Exercise** | Never0-2 x week2-5 x week5 + x week | IntenseModerateEasy going | Bike WalkSwim HikeRun GymWeightsSports: | Other: |
| **Lifestyle** | Spiritual participationYogaTai chiChi KungMeditationOther:   | KnittingCrochetingQuiltingPainting DrawingPhotographyReadingOther: | 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.*