



Patient Name: _____ Sex: F M

Age: _____ Date of Birth: _____ SSN*: _____ Marital Status: _____

Address _____

City _____ State _____ Zip _____

Living With: Alone _____ Spouse/Partner _____ Parents _____ Children _____ Other _____

Daytime Phone: _____ Leave Message? Y N

Evening Phone: _____ Leave Message? Y N

Cell Phone: _____ Leave Message? Y N

Email Address: _____

Occupation: _____ Hours Worked Per Week _____

Emergency Contact: _____ Relationship to You: _____

Phone: _____

Primary Care Provider: _____

Address: _____

Phone: _____

How did you hear about us?

Reason for Visit Today:

* Social Security Number required for billing collections only. Should an outstanding balance not be paid by due date, your SSN may be provided to a local collections agency. It will not be used, or shared, for any other purpose. Please see our Privacy Practices handout for more information.



Health Concerns:

Please list your current health concerns in order of most to least bothersome.

1. _____
2. _____
3. _____
4. _____

How committed are you to making appropriate lifestyle changes to support your healing process?

(0 = not willing to make any changes, 10 = fully committed to making all changes)

0 1 2 3 4 5 6 7 8 9 10

What aspects of your life do you feel support a healthy lifestyle and/or will support you in making lifestyle changes?

What aspects of your life do you feel do not support a healthy lifestyle and/or may potentially make it difficult to follow through with your commitment to getting well?

Medical History:

Hospitalizations, Surgeries or Major Illnesses: (please list date and condition or procedure)

1. _____
2. _____
3. _____
4. _____

Current Medications: (prescription and over the counter)

Medication	Used to Treat	Dosage
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		



Current Supplements:

Supplement	Reason for Taking	Dosage
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Allergies: (medication, food, environmental or any other known allergies)

Past Medical/Screening Exam History:

Please list any chronic, or previously diagnosed illnesses: _____

Last Blood Work: (date and blood work run) _____

Ever had a colonoscopy? Y N If yes, when and results? _____

Ever had bone density test? Y N If yes, when and results? _____

Last Woman's Wellness Exam _____ Ever have abnormal Woman's exam? Y N

Last Prostate Exam _____ Ever have abnormal Prostate exam? Y N

Family History:

Please indicate any significant family history:

Condition	Family Member(s)
Alcoholism/Addiction	_____
Allergies	_____
Alzheimer's Disease	_____
Anxiety Disorder (generalized, panic disorder, OCD)	_____
Arthritis	_____
Asthma	_____
Autoimmune Condition	_____
Cancer	_____
Depression / Bipolar Disorder	_____
Diabetes	_____
Epilepsy/Seizures	_____
Heart Disease	_____



High Blood Pressure _____
 Thyroid Disease _____
 Tuberculosis _____
 Other _____

Social History:

Do you exercise? Y N If yes, how often and what type? _____

Main interests or hobbies _____

Major sources of stress (Past or Present) _____

Do you have a history of any major traumas? Y N

What do you do for stress relief? _____

Do you have an active spiritual practice? _____

How many hours of sleep do you get per night, on average? _____

Do you wake feeling rested? Y N

How would you rate your daily energy level overall? (0 = can't complete daily tasks due to lack of energy, 10 = have enough energy to complete all necessary tasks without fatigue)

0 1 2 3 4 5 6 7 8 9 10

Drug/Alcohol/Tobacco History:

Please indicate any substance you're currently using, or have used in the past

Substance	Current Use	Amount	Frequency	Past Use
Caffeine				
Alcohol				
Tobacco				
Marijuana				
Pain Killers				
Inhalants				
Sleeping Pills				
Diet Pills				
Laxatives				
Steroids				
Methamphetamines				
PCP/LSD/Mushrooms				
Ecstasy				
Cocaine/Crack				
Heroin				



Dietary History:

Current Weight_____ Max Weight_____ Min Weight (as adult)_____ Desired Weight_____

How many meals do you eat per day? _____

Do you skip meals? Y N

Do you cook meals? Y N If yes, how many days per week? _____

Do you eat vegetables daily? Y N

Do you eat fruit daily? Y N

Do you eat fast food? Y N If yes, how often? _____

Are you following any special or restricted diet? Y N If yes, please describe _____

Water intake in ounces per day _____

Do you drink soda? Y N If yes, how many ounces per day? _____

Do you drink coffee? Y N If yes, how many ounces per day? _____

Do you drink alcohol? Y N If yes, how many drinks per week? _____

Mental Health History:

Have you ever been in counseling/therapy before? Y N

If yes, did you find it helpful or effective? Y N

Are you currently receiving mental health services? Y N

If yes, please list the name of practitioner and type of service you're receiving _____

Have you ever been diagnosed with a mental illness? Y N

If yes, please list which illness(es) and date(s) diagnosed: _____

Have you ever been hospitalized for a mental health concern? Y N

If yes, please list date(s), length of stay and reason for hospitalization: _____

Have you ever, or are you currently engaging in self-harm behaviors? Current Past Never

Have you ever, or are you currently contemplating suicide? Current Past Never

Have you ever attempted suicide? Y N

If yes, please list date(s) and method(s) of attempt: _____



Has anyone in your life ever attempted or committed suicide? Y N

If yes, what was their relationship to you? _____

Have you ever contemplated harming someone else? Current Past Never

Have you ever been the victim of abuse (verbal, physical, sexual)? Current Past Never

Please circle all symptoms/behaviors that you've experienced and indicate if they're currently problematic or have been in the past:

Distractibility	Current	Past	N/A
Hyperactivity/Excessive Energy	Current	Past	N/A
Impulsivity	Current	Past	N/A
Wide Mood Swings	Current	Past	N/A
Over Confidence	Current	Past	N/A
Shy/Timid	Current	Past	N/A
Changes in Appetite/Eating Behavior	Current	Past	N/A
Suspicion/Paranoia/Jealousy	Current	Past	N/A
Aggression/Fights	Current	Past	N/A
Hearing Voices	Current	Past	N/A
Visual Hallucinations	Current	Past	N/A
Irritability/Anger	Current	Past	N/A
Increased/Decreased Need for Sleep	Current	Past	N/A
Delusions	Current	Past	N/A
Sexual Problems/Promiscuity	Current	Past	N/A
Lack of Motivation	Current	Past	N/A
Loss of Pleasure/Interest	Current	Past	N/A
Withdrawal from People	Current	Past	N/A
Sadness/Depression	Current	Past	N/A
Low Self -Worth	Current	Past	N/A
Crying Spells	Current	Past	N/A
Loneliness	Current	Past	N/A
Guilt/Shame	Current	Past	N/A
Fatigue	Current	Past	N/A
Racing Thoughts	Current	Past	N/A
Anxiety/Worry	Current	Past	N/A
Poor Memory/Confusion	Current	Past	N/A
Panic Attacks	Current	Past	N/A
Fear Away from Home	Current	Past	N/A
Nightmares	Current	Past	N/A



Social Discomfort	Current	Past	N/A
Obsessive Thoughts	Current	Past	N/A
Compulsive Behavior	Current	Past	N/A
Thoughts of Death	Current	Past	N/A
Relationship Problems	Current	Past	N/A
Flashbacks	Current	Past	N/A
Recurring Disturbing Memories	Current	Past	N/A

Review of Systems:

Please indicate if you are experiencing any of the following, either currently or in the past:

Current	Past	General	Current	Past	Skin/Hair
		Anemia			Acne
		Fatigue, Lack of Energy			Hives/Rashes
		Sadness/Depression			Ulcers/Sores
		Worry/Anxiety			Dry, rough or scaling skin
		Irritability			Hair loss
		Frequent colds, recurrent infections			Dandruff/itchy scalp
		Too much, too little or night sweats			Easy bruising
		Chronically swollen glands			Fungal infections
		Recurrent Fever/Chills			Brittle or ridged nails
					Warts or moles
		Head			Eczema/Psoriasis
		Migraines			Poor Wound Healing
		Headaches			
		TMJ			Eyes
		Head Injury			Wear glasses or contacts
					Blurry vision
		Ears			Dry, burning or itchy eyes
		Frequent ear infections			Excessive tearing
		Discharge from ears			Red or puffy eyes
		Ringing in ears			Dark circles under eyes
		Difficulty hearing			Discharge or crusts in eyes
					Sensitivity to light
		Nose and Throat			Pain in eyes
		Allergies, sinusitis, runny nose			



	Dry mouth or nose		Cardiovascular
	Frequent nosebleeds or bleeding gums		Chest pain
	Sores, ulcers, cuts in mouth/on lips		Heart disease
	Sore, discolored or cracked tongue		High/Low blood pressure
	Hoarseness of voice		Ankle or leg swelling
	Loss of smell or taste		Rheumatic fever
	Nasal polyps		Angina
	Excessive or decreased saliva		Heart murmur
	Frequent sore throats		Fainting spells
	Difficulty swallowing		Palpitations
			Cold hands or feet
	Respiratory		Extremity discoloration
	Cough		Deep pain in legs
	Spitting up blood		
	Pneumonia		Neurologic
	Asthma		Weakness
	Shortness of breath		Paralysis
	Tuberculosis		Numbness/Tingling
	Painful breathing		Seizures
	Wheezing		Tremors
	Difficulty breathing when lying down		
			Urinary
	Gastrointestinal		Kidney disease
	Changes in appetite		Incontinence
	Nausea or vomiting		Painful urination
	Foul taste in mouth		Difficult urination
	Stomach ulcers		Retention of urine
	Heartburn / Indigestion		Blood in urine
	Excessively full feeling after eating		Increased urinary frequency
	Bloating		Frequent UTI's
	Excessive Gas		Kidney Stones
	Belching		Bed Wetting
	Constipation		
	Diarrhea		Endocrine
	Floating or discolored stool		Increased or Deceased thirst
	Blood in stool		Cold or heat intolerance
	Painful bowel movements		Diabetes
	Hemorrhoids		Weight Changes



		Rectal pain or itching			Fatigue
					Hypo/hyperglycemia
		Female			Hypo/hyperthyroidism
		Irregular menstrual cycle			
		Heavy menstrual cycle			Male
		Painful menstrual cycle			Prostate disorder
		Premenstrual Syndrome			Genital discharge
		Vaginal pain or discharge			Rashes or Sores
		Pain with intercourse			Pain in genitals
		Increased or Decreased Sex Drive			Sexually transmitted infection
		Pregnancy			Changes in sex drive
		Miscarriages			Sexual difficulties
		Abortions			
		Difficulty conceiving			Musculoskeletal
		Sexually transmitted infection			Back pain
		Pelvic Pain			Neck pain
		Painful or swollen breasts			Joint pain/stiffness
		Hot flashes			Muscle tension
		Menopausal Symptoms			Arthritis
		Endometriosis			Muscle cramps or spasms
					Sciatica
					Broken bones

By signing below, I attest that all information provided above is correct and accurate to the best of my knowledge.

Printed name of patient or legal guardian

Singed name of patient or legal guardian

Date