



Name _____ date _____
email _____ phone number(s) _____
address _____
gender _____ occupation _____
please circle one
single married divorced widowed living with partner other _____
birth date, time, and location _____
physician, therapist, and/or other health care practitioner's contact information
name(s) _____ phone number(s) _____

May I contact above health care provider(s)?

emergency contact _____ relationship _____ phone number _____

Reason(s) for visit _____

How long has this been affecting you?

List other forms of treatment you are involved in?

List medications you are currently taking and for how long.
(include herbal remedies and/or supplements)

Are you currently using or have a history of using any of the following:
(please explain and list quantity & frequency)
cigarettes, alcohol, caffeine, other drugs (please list)

Indicate what best reflects your symptoms or other concerns

General

- Insomnia
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Mental Health

- Depression
- Mood swings
- Irritability
- Mania
- Dreams/ nightmares

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness/Vertigo
- Fainting
- Swollen glands

Ears

- Ringing (high/low)
- Hearing loss
- Infections
- Earache
- Hearing aids

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts
- Dry Eyes

Nose, Throat & Mouth

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Excessive phlegm
- TMJ
- Gum problems

- Dry Mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Heat on Palms/Soles/Chest
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing lying down
- Wheezing
- Asthma
- Chronic cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight/Pain chest
- Pneumonia

Cardiovascular

- High/Low Blood Pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Abdominal pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of STD: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

Other (describe)

