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| Personal Information |
| Patient Name: First Last Middle Initial |
| Address: Street Apt. No |
| City County State Zip |
| Phones: Home Work Cell |
| Email: Fax: |
| Age: DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender: Male/Female |
| SSN: |
| Race/Ethnicity/Nationality: |
| Occupation: Job Title: |
| Employer Name: Employer Phone: |
| Highest Education Completed: High School Associates Bachelors Masters Doctorate |
| Emergency Contact: Name Relationship Phone |
| Address Apt. No |
| City County State Zip |
| How did you hear about us? Website Direct Mailer/Postcard Facebook |
| Friend/Family \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_ |

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| Insurance Information |
| Primary Health Insurance ID# Group# |
| Secondary Health Insurance ID# Group# |
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| Pharmacy Information |
| Primary Pharmacy: Name Phone FAX |
| Address |
| City State Zip |

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| Health Care Providers | | | | | | | |
| Primary Doctors | | | | | | | |
| Name | | **Phone Number** | | **City, State** | | **Last Visit** | |
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| Specialists | | | | | | | |
| Name | **Specialty** | | **Phone Number** | | **City, State** | | **Last Visit** |
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| Nutritionist/Dietician | | | | | | | |
| Name | | **Phone Number** | | **City, State** | | **Last Visit** | |
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| Naturopath(s) and/or Homeopath(s) | | | | | | | |
| Name | | **Phone Number** | | **City, State** | | **Last Visit** | |
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|  | |  | |  | |  | |
| Therapist(s) and/or Counselor(s) | | | | | | | |
| Name | **Specialty/Type** | | **Phone Number** | | **City, State** | | **Last Visit** |
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|  |  | |  | |  | |  |
| Other | | | | | | | |
| Name | **Specialty** | | **Phone Number** | | **City, State** | | **Last Visit** |
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| Allergies | |
| Medication/Supplement/Food | **Reaction** |
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| Medications | | | | | |
| Please include Over-the-Counter (OTC) Medications | | | | | |
| Name and Dose/Strength | **Number, Frequency Per Day** | **Good Response** | **No Response** | **Bad then Good** | **Side Effects** |
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| Vitamins, Minerals, Herbs, Homeopaths and Other Supplements | | | | | |
| Please only list supplements you are currently or have recently taken. | | | | | |
| Name and Dose/Strength | **Number, Frequency Per Day** | **Good Response** | **No Response** | **Bad then Good** | **Side Effects** |
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| Past Medications and Supplements | | | | | |
| Please only list supplements you are no longer taking or have not taken recently. | | | | | |
| Name and Dose/Strength | **Number, Frequency Per Day** | **Good Response** | **No Response** | **Bad then Good** | **Side Effects** |
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| Concerns/Complaints | | | | | | | | | | |
| What are three problems you wish could be taken away? | | | | | | | | | | |
| 1) | | | | | | | | | | |
| 2) | | | | | | | | | | |
| 3) | | | | | | | | | | |
| Current and Ongoing Problems Success | | | | | | | | | | |
| Describe Problem: onset, frequency | | Mild | Moderate | Severe | **Prior/Current Treatment** | | | Great Help | Some Help | Made Worse |
| Ex: Eczema | |  |  |  | **Steroid Cream** | | |  |  |  |
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| Medical History | | | | | | | | | | |
| Include any chronic or recurring disease/condition or previously treated disease/condition | | | | | | | | | | |
| Examples of chronic or recurring problems – Diabetes, Fibromyalgia, Recurring Sinusitis, etc  Examples of treated problems no longer affecting you – Meningitis, Pneumonia, etc | | | | | | | | | | |
| Disease/Condition | **Current Treatments** | | | | | **Past Treatments** | **Length of Treatment** | | | |
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| Surgical History | |
| None | |
| Date | **Reason** |
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| Hospitalizations | |
| None  Please do NOT include Surgeries already listed unless complications occurred. | |
| Date | **Reason** |
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| Injuries | |
| Example: Back, Neck, Head, Broken Bones, etc. | |
| Date | **Reason** |
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| Female History |
| Age at First period \_\_\_\_\_ Date of Last Period \_\_\_/\_\_\_/\_\_\_ |
| Length of cycles (days period lasts) \_\_\_\_ Frequency (ex: 28 days) \_\_\_\_\_ |
| History of irregular/abnormal periods? \_\_\_\_ If yes, please describe: |
|  |
| Please circle if you have a history of: Endometriosis Fibroids PCOS Infertility Painful Periods Heavy Periods Clots PMS Breast Tenderness Yeast |
|  |
| Please circle hormonal birth control: OCP (pill) IUD Vaginal Ring Patch None |
| How long? If None, have you ever used any type? |
|  |
| Form of contraception if not already circled: Condom Diaphragm IUD “Pull Out” Partner Vasectomy |
| Last Pelvic Exam? |
| Have you ever had an abnormal Pap test? \_\_\_\_ If yes, please elaborate: |
|  |
| Pregnancies: None \_\_\_\_ Full Term \_\_\_\_ Miscarriage \_\_\_\_ Abortion \_\_\_\_ |
| Living Children \_\_\_\_ Premature \_\_\_\_ Birth Wt of heaviest baby \_\_\_\_ , smallest \_\_\_\_ |
| Currently Pregnant? \_\_\_\_\_ Due Date? \_\_\_/\_\_\_/\_\_\_ |
| Complications during pregnancy, labor, or deliver? |
|  |
| If you have never been pregnant, do you wish to have children in the future? \_\_\_ |
| If you have children, do you plan to have more? |
| Did you (or do you plan to) breast feed your children? |
|  |
| Are you in menopause? \_\_\_\_ What age did menopause occur? \_\_\_\_ |
| Menopausal Symptoms (please circle)? Hot Flashes Mood Swings Vaginal Dryness Decreased Libido (sexual desire) Weight Gain Concentration/Memory Problems Headaches Heart Racing |
|  |
| Hormone Replacement Therapy? \_\_\_\_ How long? \_\_\_\_\_ |

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| Male History |
| Have you had a PSA test? \_\_\_ Year? \_\_\_ |
| PSA level (please circle)? 0-1 1-2 2-4 4-10 >10 |
|  |
| Please circle any of the following issues: Prostate Enlargement Prostate Infections Change in Sexual Desire Impotence Difficulty Getting or Maintaining an Erection |
|  |
| Night time Urination? \_\_\_\_ How many times/night? \_\_\_\_ |
|  |
| Urgency/Hesitancy/Change in Urine Stream |

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| Birth/Childhood History |
| Did you mother have any known problems or complications during her pregnancy with you such as: smoking, illnesses, alcohol, medications, or vaccines? |
|  |
| Full-term? \_\_\_\_ If premature, how many weeks? \_\_\_\_ |
| Birth Complications? |
| Breastfed? \_\_\_\_ How long? \_\_\_\_\_ |
|  |
| Please circle if any of the following childhood illnesses: Colic Reflux Meningitis  Frequent Ear, Throat or other Infections Thrush Asthma Eczema Chicken Pox  Frequent Colds ADD/ADHD |
|  |
| Frequent Antibiotics? \_\_\_\_ Frequent Steroids? \_\_\_\_ |
|  |
| Would you describe your childhood experience as happy? |
|  |

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| Tattoos or Body Piercings |
| Please include location: |
|  |

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| --- | --- |
| Family History | |
| List any major illnesses, genetic diseases or problems (digestive, mental health, etc.)  \*\* If family member is deceased, please list their age at death and cause. | |
| Mother |  |
| Father |  |
| Brothers |  |
| Sisters |  |
| Maternal Grandmother |  |
| Maternal Grandfather |  |
| Paternal Grandmother |  |
| Paternal Grandfather |  |
| Other |  |

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| Preventive Tests | |
| Test | **Please provide approximate date if you have had the test** |
| Full Physical w/in 1-2 yr |  |
| Bone Density Exam |  |
| Cardiac Echocardiogram |  |
| Cardiac Stress Test |  |
| Colonoscopy |  |
| Mammogram w/in 2 years |  |
| Other |  |

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| Social History |
| Tobacco |
| Current smoker? \_\_\_ If yes, how many packs per day? \_\_\_\_ How many years? \_\_\_\_ |
| How soon after you wake up do you smoke? <5 min 5-30 min 31-60 min >60 min |
| How many times have you tried to quit? \_\_\_\_ What is the longest you quit? \_\_\_\_ |
| Have you thought about quitting? |
| Smoking cessation aids? Nicotine gum/patch/lozenge Hypnosis Biofeedback  Medication? |
| Previous smoker? \_\_\_ If yes, how many packs per day? \_\_\_\_ How many years? \_\_\_\_ |
| Do you live with any smokers? \_\_\_ |
| Other type of tobacco? |
|  |
| Alcohol |
| How many alcohol drinks per week? 1 drink = 12 oz. of beer, 5 oz. of wine, 1.5 oz. of liquor  NONE 1-2 3-4 5-6 7-10 10-15 16-20 >20 |
| What type of drinker would you describe yourself as? Light Social Moderate Heavy |
| Have you ever been told you should cut down on your drinking? \_\_\_ |
| Do you get annoyed when people ask about your drinking? \_\_\_ |
| Do you ever feel guilty about the amount of alcohol you drink? \_\_\_ |
| Do you ever drink an “eye-opener”? \_\_\_ |
| Have you ever had memory loss or “blacked out” from drinking? \_\_\_ |
| Do you feel that you have a high tolerance for alcohol compared to others? \_\_\_ |
| Do you get into arguments or fights when you have been drinking? \_\_\_ |
| Have you ever been arrested or hospitalized because of drinking? \_\_\_ |
| Have you ever thought about getting help to control or stop drinking? \_\_\_ |
|  |
| Illicit/Illegal Drugs |
| Do you use any illegal/street drugs? \_\_\_ What do you use? \_\_\_ |
| Former drug use? |
| Any history of IV drug use? |
| Have you ever sought help for your drug use? |

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| Social History |
| Psychosocial |
| Marital Status (please circle): Single Married Divorced Long-Term Partnership Widow |
| Who lives with you at home? Include children, parents, relatives, friends, etc. Include ages. |
|  |
|  |
| Recent changes, major losses, births, deaths, divorce, moves, remarriage, etc. |
|  |
| History of Abuse? \_\_\_\_ Sexual, Emotional and/or Physical? \_\_\_\_\_ |
| Ongoing or Past? \_\_\_\_ |
| Do you Feel Safe at Home? |
|  |
| List the three greatest Stressors in your life: |
| 1) |
| 2) |
| 3) |
| What is your greatest fear? |
|  |
| Are you happy? |
| Do you feel like your life has meaning and purpose? |
| Do you like the work you do? |
| Do you feel you have an excessive amount of stress in your life? |
| Do you feel you easily cope with stress? |
| Rate your Daily Stressors on a scale of 1-10  Work \_\_\_ Family \_\_\_ Social/Friends \_\_\_\_ Finances \_\_\_\_ Health \_\_\_\_ Other \_\_\_\_ |
|  |
| Describe any Relaxation or Stress Management Techniques you use and how often: |
|  |
| Please circle all that apply: Yoga Meditation Breathing Prayer Tai Chi Imagery |
|  |
| How important is religion/spirituality in your life on a scale of 1-10? \_\_\_\_ |
| What religion do you identify yourself as? |
|  |

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| Social History |
| Sleep |
| Average *total* number of hours of sleep per night? |
| Average *continuous* number of hours of sleep per night? |
| Do you trouble falling asleep? Do you have trouble staying asleep? |
| Quality of sleep (please circle)? Well Rested Tired on Awakening Frequent Awakenings |
| Do you Snore? \_\_\_ Do you use sleeping aids? \_\_\_ Explain: |
| How likely are you to doze off or fall asleep in the following situations (0-3)? \*Not just tired  0 = would NEVER dose 1 = SLIGHT Chance 2 = Moderate Chance 3 = High Chance |
| Sitting and Reading \_\_\_ |
| Watching TV \_\_\_ |
| Sitting, inactive in a public place \_\_\_ |
| As a Passenger in a car for an hour without a break \_\_\_ |
| Lying down to rest in the afternoon when circumstances permit \_\_\_ |
| Sitting and talking to someone \_\_\_ |
| Sitting quietly after a lunch without alcohol \_\_\_ |
| In a car, while stopped for a few minutes \_\_\_ |
| Total Score \_\_\_ |
|  |
| Relationship/Sexual |
| How do you identify yourself? Male Female Gay/Lesbian Transgender Bisexual |
| Sexually Active? \_\_\_\_ If not active, when was your last sexual encounter? |
| Number of sexual partners in the last 3 months? \_\_\_\_ Lifetime? \_\_\_\_ |
| Do you prefer Men, Women, or Both? |
| Do you use protection/prophylaxis? Condoms Diaphragm Female Condom |
| Are you satisfied with your sex life? |
|  |

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| Social History | | | | |
| Depression | | | | |
| In the past 2 weeks, how often have you been bothered by any of the following problems? | | | | |
| Please circle a number for each question | **Not at all** | **Several Days** | **More than half the days** | **Nearly every day** |
| Little interest or pleasure in doing things | **0** | **1** | **2** | **3** |
| Feeling down, depressed, or hopeless | **0** | **1** | **2** | **3** |
| Trouble falling or staying asleep, or sleeping too much | **0** | **1** | **2** | **3** |
| Feeling tired or having little energy | **0** | **1** | **2** | **3** |
| Poor appetite or overeating | **0** | **1** | **2** | **3** |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down | **0** | **1** | **2** | **3** |
| Trouble concentrating such as reading or watching tv | **0** | **1** | **2** | **3** |
| Moving or speaking so slowly that other people could have noticed? Or being overly fidgety or restless? | **0** | **1** | **2** | **3** |
| Thoughts that you would be better off dead or of hurting yourself in some way | **0** | **1** | **2** | **3** |
| For office coding | **0** |  |  |  |
| Total Score: \_\_\_\_\_\_ | | | | |

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| Social History |
| Exercise |
| Do you exercise? \_\_\_\_ How many days/week? \_\_\_\_ How many min/day? \_\_\_\_ |
| How hard do you typically exercise? Light Moderate Heavy |
| Do you typically sweat when exercising? |
| What type of exercise do you do? |
| What physically limits you from exercising more often? |
|  |
| Nutrition |
| How would you rate your diet? Very Healthy Healthy Somewhat Healthy Unhealthy |
| Special diet (circle all that apply)? Low-Fat Low-Carb Low-Protein Atkins  Weight Watchers Jenny Craig Gluten-Free Casein-Free Candida Diet  Specific Carbohydrate Diet Ketone Diet South Beach Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many times a day do you eat? |
| What are your favorite snacks? |
| Do you do the grocery shopping for your household? |
| Do you read food labels? |
| How many meals do you eat out per week? 0-1 1-3 3-5 >5 |
| Do you avoid certain foods? \_\_\_ Why? |
|  |
| What are you typical food “cravings”? |
|  |
| What percentage of your diet is Organic? |
| How willing are you to change your diet if recommended (1-10)? |
|  |
| Water |
| Ounces of water per day? Type of water (city, well, bottle, filter)? |
|  |
| Caffeine |
| Coffee cups/day? \_\_\_\_ Tea glasses/day? \_\_\_\_ Soda 12-oz/day? \_\_\_\_\_ Diet? \_\_\_\_ |
| Do you drink energy drinks like Monster or Redbull? \_\_\_\_ How many/day? \_\_\_\_ |

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| 3-Day Food Diary | | |
| Please record your daily food and drink as accurately as possible.   * Do Not change your eating behavior from normal – the more typical the better * Enter food/drink as close to time as possible to consuming * Describe the food or beverage as accurately as possible (e.g. wheat or white bread, 2% or whole milk, baked or fried) * Attempt to record the amount of food – preferably using measurements * Accurately describe BEVERAGES i.e. what type and how much * Note if from HOME, RESTAURANT, or CONVENIENCE STORE/Gas Station * Record BOWEL MOVEMENTS and consistency (firm, loose, etc.) | | |
| Day 1 |  |  |
| TIME | **Food/Beverage/Amount** | **Comments** |
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| Bowel Movements | | |
| Stress/Mood/Emotions | | |
| 3-Day Food Diary | | |
| Please record your daily food and drink as accurately as possible.   * Do Not change your eating behavior from normal – the more typical the better * Enter food/drink as close to time as possible to consuming * Describe the food or beverage as accurately as possible (e.g. wheat or white bread, 2% or whole milk, baked or fried) * Attempt to record the amount of food – preferably using measurements * Accurately describe BEVERAGES i.e. what type and how much * Note if from HOME, RESTAURANT, or CONVENIENCE STORE/Gas Station * Record BOWEL MOVEMENTS and consistency (firm, loose, etc.) | | |
| Day 2 |  |  |
| TIME | **Food/Beverage/Amount** | **Comments** |
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| Bowel Movements | | |
| Stress/Mood/Emotions | | |

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| 3-Day Food Diary | | |
| Please record your daily food and drink as accurately as possible.   * Do Not change your eating behavior from normal – the more typical the better * Enter food/drink as close to time as possible to consuming * Describe the food or beverage as accurately as possible (e.g. wheat or white bread, 2% or whole milk, baked or fried) * Attempt to record the amount of food – preferably using measurements * Accurately describe BEVERAGES i.e. what type and how much * Note if from HOME, RESTAURANT, or CONVENIENCE STORE/Gas Station * Record BOWEL MOVEMENTS and consistency (firm, loose, etc.) | | |
| Day 3 |  |  |
| TIME | **Food/Beverage/Amount** | **Comments** |
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| Bowel Movements | | |
| Stress/Mood/Emotions | | |