CONFIDENTAL PATIENT HISTORY

NAME_____HEIGHT_____WEIGHT_____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH_____ MARITAL STATUS: Single ____Married ____Widowed ____Divorced___

HOME TELEPHONE_____CELL_____

EMAIL ADDRESS_____

PERMISSION TO CONTACT YOU BY EMAIL Yes_____ No_____

OCCUPATION_____EMPLOYER_____

SPOUSE/PARTNER'S NAME_____EMPLOYER_____

SPOUSE/PARTNER'S CELL PHONE_____

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY_____

RELATIONSHIP:_____ CELL PHONE_____

HOW DID YOU CHOOSE OUR OFFICE/WEBSITE?(eg. Referral, internet, etc)_____

WHAT'S IS THE MAIN PROBLEM OR SYMPTOM THAT MADE YOU COME HERE TODAY?_____

_____

WHEN AND HOW DID THIS BEGIN?_____

HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST **YES**_____ **NO**_____, **WHEN?**_____

WHAT AGRAVATES YOUR CONDITION?_____

WHAT MAKES IT BETTER?_____

DESCRIBE WHAT ARE YOU FEELING_____

DO YOU EXPERIENCE NUMBNESS OR TINGLING? **NO** _____ **YES**_____ **IF YES, WHERE?** _____

SYMPTOM INTENSITY: PLEASE PLACE AN **X** ON THE NUMBER DESCRIBING THE INTENSITY OF YOUR SYMPTOMS.

NONE 1 2 3 4 5 6 7 8 9 10 **UNBEARABLE**

WHEN YOU ARE AWAKE, HOW OFTEN ARE YOU FEELING THESE SYMPTOMS? (0-100%) _____%

IS THIS GETTING PROGRESSIVELY WORSE? **YES**___ **NO** ____

IS YOUR CONDITION: **CONSTANT**_____ **COMES & GOES**_____

IS THIS CONDITION INTERFERING WITH YOUR: **WORK**___ **SLEEP**___**DAILY ROUTINE**___**OTHER**_____

LEVEL OF STRESS: PLEASE PLACE AN **X** ON THE NUMBER DERCRIBING THE INTENSITY OF YOUR STRESS.

LOW 1 2 3 4 5 6 7 8 9 10 **HIGH**

IN LAST 3 YEAR'S HAVE YOU EXPERIENCED ANY OF THE BELOW:

DIVORCE___ DEATH IN FAMILY___ LOSS OF PET___ CHANGE/LOSS OF JOB___ SEVERE ILNESS___

MOVE OF RESIDENCE___AUTO ACCIDENT___ INSOMNIA___ NIGHT SWEATS___

HAS THERE BEEN ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT? **YES____ NO____ IF YES, LIST THE DR'S NAME AND THE DIAGNOSIS**_____

HOW HAVE YOU TRIED TO TAKE CARE OF THIS PROBLEM IN THE PAST? CHECK ALL THAT APPLY

MEDICATIONS___EMERGENCY ROOM___SURGERY___ROUTINE MEDICAL___EXERCISE___SUPPLEMENTS___REGULAR CHIROPRACTIC___ OTHER (PLEASE SPECIFY)_____

HOW DID THE PREVIOUS METHOD(S) WORK OUT FOR YOU? CHECK ALL THAT APPLY

BAD RESULTS___ SOME RESULTS___GREAT RESULTS___NOTHING CHANGED___DIDN'T GET WORSE___DIDN'T WORK VERY LONG___

WHAT ARE YOU AFRAID THIS MIGHT BE?_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKE AND FOR WHAT CONDITIONS:_____

_____

_____

PLEASE LIST ANY NATURAL SUPPLEMENTS YOU CURRENTLY TAKE AND FOR WHAT CONDITIONS:_____

_____

_____

_____

PLEASE LIST **5 MAJOR HEALTH CONCERNS** IN ORDER OF IMPORTANCE TO YOU.

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

PLEASE USE THE SPACE BELOW TO GIVE US MORE DETAILS ABOUT THE HISTORY OF YOUR PROBLEM(S).
PLEASE TELL US ABOUT:

- WHEN THESE PROBLEMS STARTED? HOW THEY HAVE CHANGED OVERTIME?
- WHAT HAVE YOU TRIED TO HELP THIS(MEDICATIONS, TERAPIES,DIETS,SUPPLEMENTS,ETC)
- WHAT WAS THE RESPOSE?(HELPED,WORSE,NO CHANGE)
- WHAT DO YOU THINK MAKES THESE SYMPTOMS/BEHAVIORS WORSE?
- WHAT DO YOU THINK MAKES THESE SYMPTOMS/BEHAVIORS BETTER.
- TELL US AS MUCH AS YOU CAN!!

SURGICAL OPERATIONS AND DATE:_____

OTHER MEDICAL OR PHYSICAL CONDITIONS YOU HAVE BEEN DIAGNOSED WITH (EG.DIABETES,HEART CONDITIONS,ARTHRITIS, OSTEOPOROSIS,LOW THYROID,HORMONE IMBALANCE, FOOD ALLERGIES,ANXIETY OR PANIC ATTACKS ETC.)_____

PLEASE WRITE **YES** OR **NO** IN THE BOX NEXT TO EACH QUESTION

	WEAKNESS		FATIGUE
	PINS AND NEEDLES FEELINGS, ELECTRIC SHOCK FEELINGS		FINGERNAILS ARE BRITTLE OR HAVE RIDGES OR LOOK DIFFERENT
	TROUBLE CONTROLLING BOWELS OR BLADDER		RACING HEART BEAT
	HAIR LOSS ON THE ARMS ANDOR LEGS		ANGINA-CHEST PAIN OR SHORTNESS OF BREATH
	BALANCE PROBLEMS		LEFT ARM PAIN
	NUMBNESS? WHERE?		SWELLING IN THE LOWER LEGS
	SYMPTOM CHANGES WITH ARM, LEG OR NECK MOVEMENTS		EXTREME SHORTNESS OF BREATH; FEEL LIKE DROWNING/SUFFOCATING
	TWITCHING MUSCLES		BLACKOUTS
	DECREASE IN SIZE OR TONE OF YOUR ARMS OR LEGS		LIGHT HEADNESS
	UNCOORDINATED		CRAMPING PAINS IN THE LEGS THAT START AFTER WALKING
	COLD ARMS, LEGS, HANDS, FEET		
	MUSCLE CRAMPING		POOR EXERCISE TOLERANCE
	DOUBLE VISION		ERECTILE DYSFUNCTION
	DIFICULTY TALKING		SENSITIVITY TO LIGHT
	YOU FEEL UNSTEADY OR YOU FALL		SWEAT MORE ON ONE SIDE (ARMPIT, FACE, ETC)
	VOMITING, SICK TO STOMACH		DRY MOUTH
	ABNORMAL JERKING OF THE EYES		DRY EYES

PAST EVALUATIONS

Here is a list of possible testing and evaluations you may have. If you have any of these please make sure to send copies of the results and reports with this questionnaire. (we do not need daily office notes).

- MRI, CT,EEG
- PSYCHOLOGICAL/NEUROPSYCHOLOGICAL EVALUATIONS
- PSYCHIATRIC
- NEUROLOGICAL EVALUATIONS
- GASTROENTEROLOGY EVALUATIONS
- REUMATOLOGY EVALUATIONS
- INTERNAL MEDICINE EVALUATIONS
- GENETIC EVALUATIONS
- CELIAC/GLUTEN TESTING

AGE	OPERATIONS
	APPENDIX
	HERNIA
	TONSILS
	HYSTERECTOMY
	GASTRIC BYPASS/RING
	GALLBLADDER
	PLASTIC SURGERY
	OTHER SURGERY
	OTHER SURGERY

PLEASE DESCRIBE ANY HEAD INJURIES, BROKEN BONES OR OTHER INJURIES/ TRAUMAS	AGE

CAN YOU RECALL WHEN WAS THE LAST TIME YOU FELT WELL? _____

_____

WHERE DO YOU PICTURE YOURSELF BEING IN THE NEXT 1-3 YEARS IF THIS PROBLEM IS NOT TAKEN CARE OF? _____

_____

WHAT WOULD BE DIFFERENT/BETTER WITHOUT THIS PROBLEM? PLEASE BE SPECIFIC_____

_____

WHAT DO YOU DESIRE MOST TO GET FROM WORKING WITH US? _____

_____

WHAT IS THAT WORTH TO YOU? _____

_____

WHAT IS YOUR IDEA OF THE IDEAL DOCTOR?_____

_____

WE THANK YOU FOR YOUR PATIENCE AND COOPERATION IN COMPLETELY FILLING OUT THIS FORM.

PATIENT SIGNATURE: _____DATE: _____