New Patient Confidential Medical Information: Name _____ Date _____

Age: _____ Chief Complaints: _____

Date condition began: _____ Is it getting worse? ____ Does it bother your sleep? ___ work?__ other? ___

Complaint result of Auto Accident? _____ Injury? ___ Job related? _____ Other? _____

What makes it better? _____

What therapies have you tried? _____

Please list other health Problems: _____

Are you under the care of a physician for these conditions? _____Please list doctor's information:

Doctors Name Address Phone

Your Primary Health Practioner:_____address _____Phone_____

Family Medical History:

- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Mental Illness
- ☐ Seizures
- ☐ Stroke
- ☐ Other

Your Past Medical History and Current Condition:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Concussions
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Surgery (list): _____
- ☐ Trauma
- ☐ Seizures
- ☐ Herpes
- ☐ Other
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ WhoopingCough
- ☐ Other (specify): _____

Your diet:

- ☐ Coffee
- ☐ Soft Drinks
- ☐ Vegetarian
- ☐ Artificial sweeteners
- ☐ Sugar
- ☐ Salty foods
- ☐ Greasy food
- ☐ Spicy Food

Thirst for water: # of glasses per Day: _____

- ☐ Appetite:
- ☐ Medium
- ☐ Low | | High

Average Daily Menu:

Morning	Snack	Noon	Snack	Evening	Snack

Please list all medications, herbs and supplements you are taking:

Your Lifestyle:

- ☐ Alcohol
- ☐ Tobacco
- ☐ Other
- ☐ Stress
- ☐ Occupational hazard
- ☐ Good Social Support
- ☐ Spiritual/religious

Time you go to sleep: _____

Time you wake up: _____

Regular exercise:
Type:_____
Frequency: _____
Other: _____

Name: _____ Date: _____

General Symptoms:

- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Dream disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Varicose veins
- ☐ Shortness of breath
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Bleed or bruise easily
- ☐ Peculiar taste (describe) _____
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Vertigo or dizzyness

Head, Eyes, Ears, Nose, Throat:

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red, itchy or hot eyes
- ☐ Floaters or spots in vision
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems (cavities, dentures, discolored, etc.)
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial Pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Excessive phlegm
- ☐ Color of phlegm: _____
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Headaches .
- ☐ Migraines
- ☐ Clogged ears
- Other: _____

Respiratory/Cardiovascular:

- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Chest pain
- ☐ Asthma/wheezing
- ☐ Cough. Wet or Dry?
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Blood clots
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Tachycardia
- ☐ Heart palpitations
- ☐ Phlebitis
- ☐ Irregular heartbeat
- ☐ Other: _____ _____

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach pain
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Bloating
- ☐ Hiccough
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Intestinal pain or Cramping
- ☐ Itch)' anus
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Hemorrhoid
- ☐ Anal fissures
- ☐ Polyps
- ☐ Diverticulosis
- ☐ Weight gain/loss
- *Bowel movement:
  - Frequency: _____
  - Color: _____
  - Texture/form: _____
  - Odor: _____

Musculoskeletal:

- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck/Shoulder pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Rib pain
- ☐ Limited range of motion
- ☐ Limited use
- ☐ Difficulty or pain with use
- ☐ Broken bones #_
- ☐ Other (specify): _____

Skin, Hair, Nails:

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations, sores
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair loss
- ☐ Change in hair or skin texture
- ☐ Fungal infections
- ☐ Weak /brittle nails
- ☐ Other (describe): _____

Neuropsychological:

- ☐ Seizure
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily Stressed
- ☐ Cry easily
- ☐ Abuse survivor
- ☐ Considered or attempted suicide
- ☐ Other (specify): _____

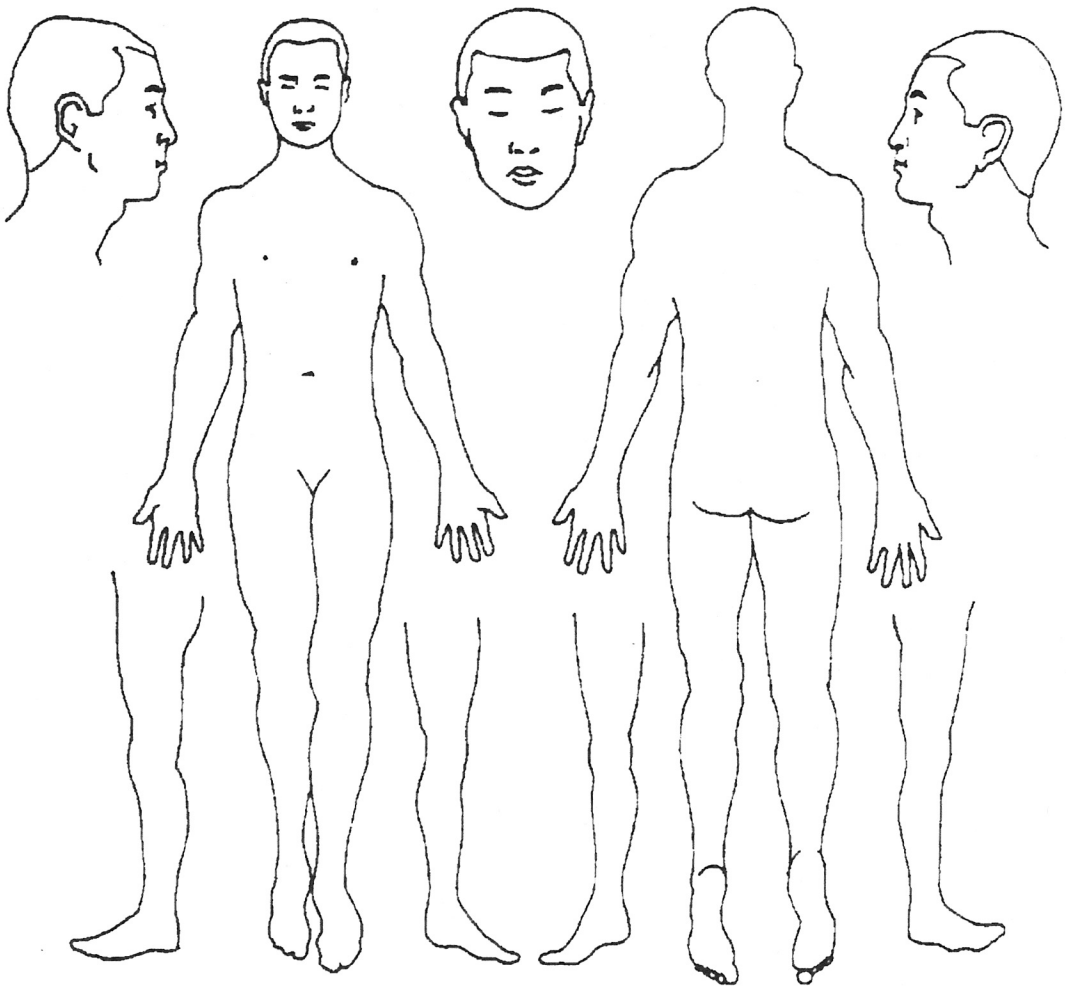
Genito-urinary:

- ☐ Frequent urination
- ☐ Abundant urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Urine w/odor
- ☐ Unable to hold urine
- ☐ Bedwetting
- ☐ Wake to urinate
- ☐ Incomplete urination
- ☐ Kidney stones
- ☐ Chronic cystitis
- *Color of Urine? _____
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Other: _____

Gynecology:

Age menses began: ___
Duration of flow:
days: ____
length of cycle (day 1 to day I)_____

- ☐ Irregular periods
- ☐ Painful periods
- ☐ clots
- ☐ PMS
- ☐ Breast Lumps
- ☐ Vaginal discharge Color:
- ☐ Vaginal sores
- ☐ Vaginal odor
- ☐ Infertility
- ☐ Recurrent yeast infections
- #Pregnancies:_
- #Live births:
- #Premature births:
- Age at menopause:_
- Date of last PAP
- Date last period began _____
- Other: _____



Indicate area/areas of complaint.