

Name: _____ Occupation: _____

Address: _____

City, State: _____

Phone Numbers: daytime, evenings: _____

Email Address: _____

Age: _____ Date of Birth: _____

Referring Physician: _____ Primary Care Physician _____

Reason for Consultation: _____

Please check any of the following whose care you are under:

- Medical doctor (MD)____ Chiropractor _____
 Psychiatrist/Psychologist____ Acupuncturist ____
 Physical Therapist/Occupational Therapist__ Other: _____

Please check all that apply and the year of diagnosis:

- | | | |
|-------------------------------|-------------------------------------|---------------------------------|
| • AIDS/HIV | • Gastroesophageal
Reflux (GERD) | • Migraines |
| • Alcoholism | • High Blood
Pressure | • Mononucleosis |
| • Anemia | • Hypoglycemia | • Multiple Sclerosis |
| • Arthritis-where | • Immune System
Disorders | • Osteoporosis |
| • Cancer | • Irritable Bowel
Syndrome | • Stomach Ulcers |
| • Cataracts | • Kidney Disease or
Stones | • Polycystic
Ovarian Disease |
| • Chemical
Dependency | • Knee Surgery | • Premenstrual
Syndrome |
| • Chronic Fatigue
Syndrome | • Liver Disease | • Prostate Problems |
| • Constipation | • Lung Disease | • Stroke |
| • Cholesterol-high | • Macular
degeneration | • Thyroid Problems |
| • Depression | • Menopause/Post
Menopause | • Ulcers |
| • Diabetes | | • Vaginal Infections |
| • Fatigue | | • Other- |
| • Fibromyalgia | | |

Surgeries: _____

Allergies: _____

List Medications and Amounts:

Check which of the following over-the-counter medication you take on a regular basis per day

- | | | |
|------------------------|---------------|----------|
| Aspirin | Laxatives | Antacids |
| Tylenol | Decongestants | |
| Advil/Motrin/Ibuprofen | Antihistamine | |

Amount of caffeine containing beverages do you drink per day?____
 If one drink equals one beer or glass of wine, how much do you drink
 at an average sittings?____ per week?____

How many packs of cigarettes do you smoke per day____

How many days per week do you use marijuana, cocaine, etc?____

How would you describe your sleep?

____Restful ____awake several time per evening ____ difficulty falling asleep
 do you wake up feeling rested? ____How many hours do you ideally require? _____

Do you follow a special diet? or use special guidelines to choose foods? How long?

Vitamin, Mineral Supplements –

please list, including brand name, amount, reason

if more space is needed, please continue on the back of this page

Herbal Supplements

please list, including brand name, amount, reason

if more space is needed, please continue on the back of this page

In the last 6 months have you had blood tests for the following. Please note those that were above or below normal range:

Folate ____ B12 ____ Iron____ Vit D____ Cholesterol____ Triglycerides____

Blood Sugar ____ Blood Pressure_____

Physical Activity and Movement:

Please list any physical disabilities_____

Please circle all activities that you enjoy and how often you do them

Aerobics	Hiking	Swimming
Ballet	Jogging	Tai Chi
Baseball	Jump Roping	Tae Kwon Do
Basketball	Karate	Tennis
Biking	Kick Boxing	Volleyball
Bowling	Play Ball	Walking
Canoeing	Skating-ice, roller, inline	Walking your dog
or Rowing	Rollerblading	Weight Lifting
Chair Exercises	Running	Yoga
Climbing	Skiing	Team Sports:_____
Dancing	Soccer	Other:_____
Football	Stretching Exercises	
Frisbee	Surfing	

If disabled, are you able to perform self-care activities?____Please *check* all that you used to enjoy and are no longer able to due to disability, time, availability of facilities or equipment, etc.

Hobbies: _____

Computer Usage – non-work related use per day: ____ (including handheld computer games)
How many hours per day do you watch TV?

Ht: ____ Wt: ____ Desired Weight: ____ Last time you were this weight: ____

Do you gain weight easily? _____

Waist Measurement: _____

Using a separate sheet of paper, please chart your weight for the last 5 - 10 years. Note any significant event around changes in your weight, including surgeries and pregnancies.

Is there a family history of weight problems? _____

Who else lives in your home? Please list their first name, relationship to you & approximate age:

Who does the grocery shopping in your household? _____

How often you eat at home? ____ per week With others? ____ per week

What kind of beverages (and the amount) do you drink daily? _____

Rate your family's support of possible lifestyle changes in your diet and physical activities:

High Medium Low

Rate your motivation level for these changes: High Medium Low

Emergency Contact: Name: _____

Phone: _____

Symptom Survey

Date:	Patient Name:	Patient Signature:
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In order to provide our patients with the best possible health care, please fill in the following form completely. Score every symptom based on your experience over the last 30 days, or since your last Symptom Survey, whichever was most recent. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:

- = 0 = Did Not Suffer From This Ever or Almost Ever
- = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**
- = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**
- = 3 = Suffered OCCASSIONALLY and symptom **was severe**
- = 4 = Suffered FREQUENTLY and symptom **was severe**

Grand Total:

CONSTITUTIONAL

- Fatigue (sluggish, tired)
- Hyperactive (nervous energy)
- Restless (can't relax/sit still)
- Sleepiness During Day
- Insomnia at Night
- Malaise (Feeling Lousy)
- _____ TOTAL (0-24)

EMOTIONAL/MENTAL

- Depression
- Anxiety
- Mood Swings
- Irritability
- Forgetfulness
- Lack of concentration/focus
- _____ TOTAL (0-24)

HEAD/EARS

- Migraine (any kind)
- Headache (other than Migraine)
- Earache
- Ear Infection
- Ringing in Ear
- Itchy Ears
- Discharge From Ears
- _____ TOTAL (0-28)

SKIN

- Blemishes, Acne
- Rashes, Hives
- Eczema
- "Rosy" Cheeks
- _____ TOTAL (0-16)

NASAL/SINUS

- Post Nasal Drip
- Sinus Pain
- Runny Nose
- Stuffy Nose
- Sneezing
- _____ TOTAL (0-20)

MOUTH/THROAT

- Sore Throat
- Swollen Throat
- Swelling of Lips/Tongue
- Gagging/Throat Clearing
- Canker Sores
- _____ TOTAL (0-20)

LUNGS

- Wheezing
- Chest Congestion
- Dry Cough
- Wet Cough
- _____ TOTAL (0-16)

EYES

- Red or Swollen Eyes
- Watery Eyes
- Itchy Eyes
- Dark Circles" or "Bags"
- _____ TOTAL (0-16)

GENITOURINARY

- Increased Urinary Frequency
- Painful Urination
- _____ TOTAL (0-8)

MUSCULOSKELETAL

- Joint Pains/Aching
- Stiff Joints
- Muscle Aches
- Stiff Muscles
- _____ TOTAL (0-16)

CARDIOVASCULAR

- Irregular Heartbeat
- High Blood Pressure
- _____ TOTAL (0-8)

DIGESTIVE

- Heartburn/Reflux
- Stomach Pains/Cramps
- Intestinal Pains/Cramps
- Constipation
- Diarrhea
- Bloating Sensation
- Gas (of Any Kind)
- Nausea, Vomiting
- Painful Elimination
- _____ TOTAL (0-36)

WEIGHT MANAGEMENT

- _____ **Record Actual Weight**
- Fluctuating Weight
- Food Cravings
- Water Retention
- Binge Eating or Drinking
- Purging (all methods)
- _____ TOTAL (0-20)