Occupation: _____ **How Long:** _____

Employer: _____ **Hours Per Week:** _____

Highest Level of Education: _____

How Did you Hear of Us?

_____ **Google** _____ **Facebook** _____ **Yelp** _____ **Pinterest**

_____ **Website** _____ **Brochure** _____ **Business Card**

_____ **Referral / from:** _____

_____ **Other**

Please list up to THREE health concerns in order of importance to you:

1.) _____

2.) _____

3.) _____

* * * *

How long have you had Concern #1? _____

Does anything make it BETTER? _____

Does anything make it WORSE? _____

* * * *

How long have you had Concern #2? _____

Does anything make it BETTER? _____

Does anything make it WORSE? _____

* * * *

How long have you had Concern #3? _____

Does anything make it BETTER? _____

Does anything make it WORSE? _____

Other Concerns? _____

_____

Do you have allergies or sensitivities to foods, environmental factors, medications, etc.?

Item	**What Happens?**
1.	
2.	
3.	
4.	
5.	

Which of the following conditions have you had in the last 6 months?

_____ **Acne**
_____ **Alcoholism**
_____ **Allergies**
_____ **Anemia**
_____ **Anxiety**
_____ **Arthritis**
_____ **Asthma**
_____ **Bleeding**
_____ **Bronchitis**
_____ **Cancer**
_____ **Chicken Pox**
_____ **Cold Sores**
_____ **Constipation**
_____ **COPD**
_____ **Depression**
_____ **Diarrhea**
_____ **Eczema**
_____ **Emphysema**
_____ **Epilepsy**
_____ **Gallstones**
_____ **Goiter**
_____ **Gout**
_____ **Hay Fever**
_____ **Headache**
_____ **Heart Attack**
_____ **Heart Failure**
_____ **Hepatitis**
_____ **High Blood Pressure**
_____ **High Cholesterol**
_____ **Influenza**
_____ **Jaundice**
_____ **Kidney Disease**
_____ **Kidney Stones**
_____ **Malaria**
_____ **Measles**
_____ **Mental Disorders**
_____ **Migraines**
_____ **Miscarriage**
_____ **Mono**
_____ **Mumps**
_____ **Obesity**
_____ **Parasites**
_____ **Pelvic Inflammatory Disease**
_____ **Pneumonia**
_____ **Prostate Issues**
_____ **Psoriasis**
_____ **Rheumatic Fever**
_____ **Rubella**
_____ **Scarlet Fever**
_____ **Sexual Abuse**
_____ **Sinusitis**
_____ **Skin Disease**
_____ **STDs**
_____ **Strep Throat**
_____ **Stroke**
_____ **Tonsillitis**
_____ **Tuberculosis**
_____ **Warts**
_____ **Whooping Cough**
Other: _____

Please list hospitalizations, operations and/or procedures below:

	What	**When**	**Complications**
1.			
2.			
3.			

Please list major injuries you have had below:

	What	**When**	**Complications/Effects**
1.			
2.			
3.			

Do you get immunizations?

	What?	**Frequency?**
1.		
2.		
3.		

What diseases or issues have your family members suffered from? Please label who is affected as follows:

M = Mother F = Father C = Child B = Brother S = Sister

Grandmother = GM Grandfather = GF

_____ Alcoholism/Addiction

_____ Allergies

_____ Arthritis

_____ Anxiety

_____ Asthma

_____ Autoimmune Disease

Type: _____

_____Cancer

Type: _____

_____Dementia or Alzheimer's

_____Depression

_____Diabetes: Insulin Dependent

_____Diabetes: Non-Insulin Dependent

_____Digestive Disorders

_____Epilepsy

_____Gallbladder Issues

_____Genetic Disease or Carrier

_____Gout

_____Hay Fever

_____Headache/Migraines

_____ Heart Attack

_____ Heart Failure

_____ High Blood Pressure

_____ High Cholesterol

_____ Hormonal Issues

_____ Insanity

_____ Joint Disease

_____ Kidney Disease

_____ Kidney Stones

_____ Mental Disorder

_____ Miscarriage

_____ Stroke

_____ Thyroid Disease

Other Family Health Concerns:

Are you currently under the care of another health care practitioner?

	Practitioner	**For What Condition?**	**Treatment**
1.			
2.			
3.			

Have you ever been treated with naturopathy, chiropractic, or functional medicine?

	Practitioner	**For What Condition**	**When?**
1.			
2.			
3.			

Do you have a dentist? Yes / No **Name:** _____ **Last visit:** _____

Dental issues? _____

Do you have a primary care provider? Yes / No **Name:** _____

Last appointment: _____ **Issues/Results:** _____

When was your last full physical? _____

Issues/Results: _____

When was your last comprehensive blood / urine screen? _____

Issues/Results: _____

Ever had a colonoscopy? Yes / No **When was the last one?** _____

Issues/Results: _____

Males: Ever had a prostate exam or PSA test? Yes / No **When was the last one?** _____

Issues/Results: _____

Females or Males: Ever had a mammogram or breast thermography? Yes / No **When was the last one?** _____

Issues/Results: _____

Females: Do you have a gynecologist, or a practitioner performing PAP smears and breast exams? Yes / No

Last appointment: _____ **Issues/Results:** _____

Females: Have you ever used birth control or an IUD? Yes / No **If so, when?** _____

Any adverse side effects?_____