

Name:

Date:

**General**

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

**Muscle / Joint**

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

**Skin**

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

**Eye, Ear, Nose & Throat**

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

**Gastrointestinal**

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen

- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**Genitourinary**

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble

**Urination**

- Overnight more than twice
- More than 8x in 24hrs
- Decreased flow/force
- Painful urination
- Urgency to urinate

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**Respiratory**

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

**Women**

- Hot flashes
  - Lumps in breast
  - Menopause
- Are you pregnant?  yes,  no  
 If yes, how many months? \_\_\_\_  
 How many children do you have?

**Check any of the conditions current or past :**

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pacemaker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

List any medications you are currently taking & why:

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**Patient Intake Form** (side 2)

Give a brief detailed description of the problem you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

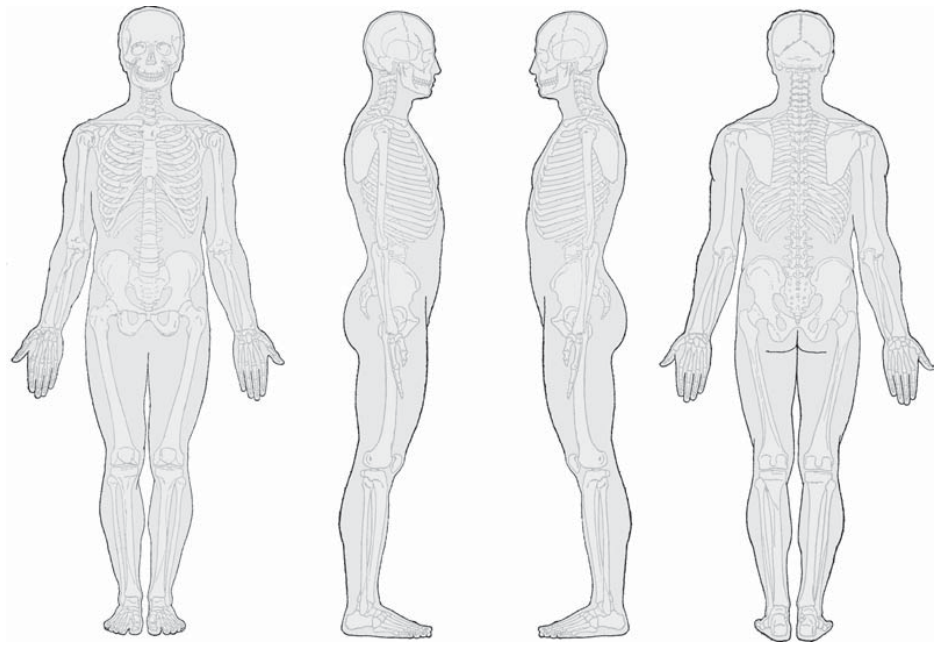
How long have you had this condition? \_\_\_\_\_ Is it getting worse?  yes,  no \_\_\_\_\_

Does it bother you (check appropriate box):  work,  sleep,  other: \_\_\_\_\_

What seemed to be the initial cause: \_\_\_\_\_

**Please mark you area(s) of pain on the figure below**

**Please place a mark at the level of your pain on the scale below:**



**Past health history**

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family history** *If any blood relative has had any of the following conditions, please check and indicate which relative(s)*

- |                                           |                                        |                                              |
|-------------------------------------------|----------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple sclerosis  |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Bleed easily     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease     |

**Do you have any other health issues or concerns that our staff should be made aware of?** \_\_\_\_\_