



2. For each of the conditions you listed above, please give a brief description of the circumstances surrounding its first appearance and what, if anything, you think might have caused or contributed to it?

(1) \_\_\_\_\_  
\_\_\_\_\_

(2) \_\_\_\_\_  
\_\_\_\_\_

(3) \_\_\_\_\_  
\_\_\_\_\_

3. For each of the conditions you listed above, please give a brief description of what, if anything, makes the condition better, and what, if anything, makes it worse? (e.g. rest/movement, hot/cold, foods, touch)

Made Better by ...

Made Worse by ...

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

4. For each of the conditions you listed above, please indicate whether you've received treatment for it previously, what the diagnosis was (and who made it), what the treatment was, and what results you experienced?

(1) Treated previously? Y or N Diagnosis? \_\_\_\_\_ By whom? \_\_\_\_\_

Treatment? \_\_\_\_\_

Results? \_\_\_\_\_

(2) Treated previously? Y or N Diagnosis? \_\_\_\_\_ By whom? \_\_\_\_\_

Treatment? \_\_\_\_\_

Results? \_\_\_\_\_

(3) Treated previously? Y or N Diagnosis? \_\_\_\_\_ By whom? \_\_\_\_\_

Treatment? \_\_\_\_\_

Results? \_\_\_\_\_

5. Please list any foods, drugs, medications or products that you are hypersensitive or allergic to:

\_\_\_\_\_  
\_\_\_\_\_

6. List all medications (prescribed and over-the-counter), vitamins, and supplements you currently take:

\_\_\_\_\_  
\_\_\_\_\_

7. Is there any chance that you may be pregnant? Y or N How far along? \_\_\_\_\_

8. Do you have any infectious diseases? Y or N If yes, please identify: \_\_\_\_\_

9. List major adulthood hospitalizations, surgeries, or illnesses in order of severity.

<u>Date</u>	<u>Treatment or Kind of Surgery</u>
(1) _____	_____
(2) _____	_____
(3) _____	_____

10. **Past Health History** (Please indicate if you have ever had any of the following.)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Abortion			Depression			Infertility		
Alcoholism			Diabetes			Mental Illness		
Allergies			Eating disorder			Miscarriage		
Anemia			Endometriosis			Panic attacks		
Arthritis			Epilepsy			PCOS		
Asthma			Fibromyalgia			Rheumatic fever		
Autoimmune disease			Heart problems			Sexual Abuse		
Blood disease			Hepatitis			Shingles		
Cancer/tumor			Herpes			Stroke		
CFIDS			High Blood Pressure			Thyroid disorder		
Chemical dependency			Low Blood Pressure			Other? _____		
Clotting disorder			High Cholesterol			Other? _____		

11. **Family History :** Father Mother Siblings Spouse Children

Age (if living) \_\_\_\_\_

Check all applicable:

Asthma/Lung disease	_____	_____	_____	_____	_____
Cancer (of what?)	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

Father's father: Alive? Y / N Age? (at death): \_\_\_\_\_ Major illness (or C.O.D.): \_\_\_\_\_

Father's mother: Alive? Y / N Age? (at death): \_\_\_\_\_ Major illness (or C.O.D.): \_\_\_\_\_

Mother's father: Alive? Y / N Age? (at death): \_\_\_\_\_ Major illness (or C.O.D.): \_\_\_\_\_

Mother's mother: Alive? Y / N Age? (at death): \_\_\_\_\_ Major illness (or C.O.D.): \_\_\_\_\_

**12. Review of Symptoms:** Please check any symptoms you currently have or have had in the past year.  
 ( Please choose the one from each shaded pair that applies to you more.)

**General**

Lower energy  
 Higher energy  
 Wake up tired  
 Tired in afternoon  
 Always tired, fatigue  
 Warmer natured  
 Colder natured  
 Chills  
 Fevers  
 Weight change

**Head & Neck**

Head injury  
 Headache  
 Visual disturbances  
 Eye pain  
 Red/inflamed eyes  
 Sinus problems  
 Nasal obstruction  
 Nasal discharge  
 Nosebleeds  
 Loss of smell  
 Earaches, chronic  
 Ear discharge  
 Hearing loss  
 Ear ringing  
 Chronic sore throats  
 Dry mouth  
 Sores on / in mouth  
 Odd tastes in mouth  
 Teeth problems  
 Other Head & Neck problems

**Respiratory**

Wheezing  
 Allergy sensitivities  
 Frequent colds  
 Bronchitis, chronic  
 Irregular coughing  
 Shortness of breath  
 Cough up phlegm  
 Cough up blood  
 Difficulty inhaling  
 Difficulty exhaling  
 Painful breathing  
 Other coughing or breathing problems

**Cardiovascular**

Chest pain  
 Chest tightness  
 Chest distension  
 Irregular heart beat  
 Heart fluttering  
 Poor circulation  
 Ankle swelling  
 Pain below ribs  
 Other heart / chest problems

**Gastrointestinal**

Abdominal pain  
 Bloating  
 Belching  
 Bad breath  
 Heartburn/Acid reflux  
 Stronger thirst  
 Weaker thirst  
 Indigestion  
 Nausea/Vomiting  
 Vomiting blood  
 Stronger appetite  
 Weaker appetite  
 Gas  
 Harder stool  
 Looser stool  
 Hemorrhoids  
 Bloody stool  
 Black stool  
 Other GI problems

**Urinary**

Clearer urine  
 Darker urine  
 Cloudy urine  
 Painful urination  
 Blood in urine  
 Frequent UTIs  
 Large quantity urine  
 Small quantity urine  
 Strong urine smell  
 Frequent urination  
 Frequent night urination  
 Poor bladder control  
 Urinary stopping and starting (poor flow)

Kidney stones  
 Other urinary problems

**Neurological**

Poor balance  
 Recent clumsiness  
 Dizziness  
 Momentary loss of balance/consciousness  
 Room spinning  
 Numbness  
 Fainting  
 Poor concentration  
 Convulsions/seizures  
 Often lost in thought  
 Extreme drowsiness  
 Other neurological problems

**Musculoskeletal**

*Pain, Weakness, or Numbness in your ...*  
 Fingers/hands  
 Arms  
 Shoulders  
 Neck  
 Upper back  
 Ribs  
 Joints  
 Toes/feet  
 Legs  
 Hips/buttocks  
 Low back pain  
 Knee problems  
 Whole body pain  
 Whole body weakness  
 Broken bones  
 Other musculoskeletal problems

**Skin & Hair**

Spontaneous sweat  
 Night sweat  
 Lack of sweat  
 Bruise easily  
 Varicose veins  
 Dry, brittle hair  
 Premature graying  
 Dry skin

Brittle nails  
 Dark under eyes  
 Acne  
 Lumps under skin  
 Blood not clotting  
 Hair falling out  
 Other skin problems

**Lifestyle & Diet**

More healthy diet  
 Less healthy diet  
 Eat 3 regular meals  
 Drink coffee  
 Drink alcohol  
 Smoke cigarettes  
 Use drugs  
 Enough exercise  
 Not enough exercise  
 Insomnia  
 Dream disturbances  
 Sad  
 Anxiety  
 Angry  
 Repetitive thinking  
 Forgetful  
 Fearful  
 Overly excitable

**Men Only**

Erection problem  
 Penis discharge  
 Low sexual energy  
 Prostate screening  
 Other problems

**Women Only**

Irregular cycle  
 Heavier periods  
 Lighter periods  
 Painful periods  
 Lighter blood  
 Darker blood  
 Blood clots  
 PMS  
 Vaginal discharge  
 Low sexual energy  
 Birth control pills  
 Regular pap smears  
 Other problems