NAME ______________________ BIRTH DATE ___/___/___ SEX ________ Single / Married / Widowed / Divorced

STREET ______________ CITY __________ ST ____ ZIP ______ PHONE # __________

REFERRED BY __________ YOUR OCCUPATION ______________ WORK # __________

EMAIL ADDRESS ______________________ CELL # __________

MAIN COMPLAINT ______________________________

PERSONAL HISTORY

HAVE YOU EVER HAD…	NO	YES	HAVE YOU EVER HAD…	NO	YES	HAVE YOU EVER HAD…	NO	YES
☐ SCARLET FEVER ☐ SCARLETINA			ANEMIA			RECURRENT DISLOCATIONS		
DIPTHERIA			JAUNDICE			☐CONCUSSIONS ☐HEAD INJURY		
SMALL POX			EPILEPSY			EVER BEEN KNOCKED UNCONSCIOUS		
PNEUMONIA			MIGRAINE HEADACHES			☐FOOD ☐CHEMICAL ☐DRUG POISONING		
PLEURISY			TUBERCULOSIS			EXPLAIN		
UNDULANT FEVER			DIABETES			☐ GONORRHEA ☐ SYPHILIS		
☐RHEUMATIC FEVER ☐HEART DISEASE			CANCER			☐ HERPES ☐ AIDS		
HEPATITIS			☐HIGH ☐ LOW BLOOD PRESSURE			ANY OTHER DISEASE		
☐ ARTHRITIS ☐ RHEUMATISM			NERVOUS BREAKDOWN			EXPLAIN		
ANY ☐ BONE ☐ JOINT DISEASE			☐ HAY FEVER ☐ ASTHMA					
☐ NEURITIS ☐ NEURALGIA			☐ HIVES ☐ ECZEMA					
☐BURSITIS ☐SCIATICA ☐LUMBAGO			FREQUENT ☐COLDS ☐SORE THROAT			WEIGHT: NOW ONE YR. AGO		
☐ POLIO ☐ MENINGITIS			FREQUENT ☐INFECTIONS ☐BOILS			MAXIMUM WHEN		
BRIGHT'S DISEASE			ANY ☐BROKEN ☐CRACKED BONES			HEIGHT: ' "		

HABITS

DO YOU…	NO	YES	DO YOU USE…	NEVER	OCC.	FREQ.	DAILY
EXERCISE ADEQUATELY			LAXATIVES				
HOW?			VITAMINS				
AWAKEN RESTED			SEDATIVES				
SLEEP WELL			TRANQUILIZERS				
AVERAGE 8 HOURS OF SLEEP (PER NIGHT)			SLEEPING PILLS, ETC.				
HAVE REGULAR BOWEL MOVEMENTS			ASPIRINS, ETC.				
SEX – ENTIRELY SATISFACTORY			CORTISONE				
LIKE YOUR WORK ( )HRS PER DAY ☐INDOORS ☐OUTDOORS			ALCOHOLIC BEVERAGE				
WATCH TELEVISION ( ) HOURS PER DAY			COFFEE ( ) CUPS PER DAY				
READ ( ) HOURS PER DAY			TABACCO: ☐CIGARETTES ( ) PER WEEK				
HAVE A VACATION ( ) WEEKS PER YEAR			☐CIGARS ☐PIPE ☐CHEWING TABACCO				
HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM			☐ MARIJUANA ☐ OTHER DRUGS				
HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE			APPETITE DEPRESSANTS				
RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK			THYROID MEDICATION: ☐NO ☐YES, IN PAST ☐NONE NOW NOW ON GR. DAILY				
			HAVE YOU EVER TAKEN…				
			☐INSULIN ☐TABLETS FOR DIABETES ☐HORMONE SHOTS ☐TABLETS ☐NO				

SURGERY

HAVE YOU HAD REMOVED…	NO	YES		NO	YES		NO	YES
TONSILS			☐ OVARY ☐ OVARIES			HAD HERNIA REPAIRED		
APPENDIX			HEMORRHOIDS			BEEN HOSPITALIZED FOR ANY ILLNESS		
GALL BLADDER			EVER HAVE A TRANSFUSION			HAD ANY OTHER OPERATIONS		
UTERUS			☐ BLOOD ☐ PLASMA			LIST…		
LIST…								

WOMEN ONLY

MENSTRUAL HISTORY…				NO	YES
AGE AT ONSET			ARE YOU REGULAR: ☐ HEAVY ☐ MEDIUM ☐ LIGHT		
USUAL DURATION OF PERIOD ( ) DAYS			DO YOU HAVE ☐ TENSION ☐ DEPRESSION BEFORE PERIOD		
CYCLE (START TO START) ( ) DAYS			DO YOU HAVE ☐ CRAMPS ☐ PAIN WITH PERIOD		
DATE OF LAST PERIOD			DO YOU HAVE HOT FLASHES		
PREGNANCIES	NO	YES			
CHILDREN BORN ALIVE (HOW MANY)			STILL BORN (HOW MANY)		
CESAREAN SECTIONS (HOW MANY)			MISCARRIAGES (HOW MANY)		
PREMATURES (HOW MANY)			ANY COMPLICATIONS		

CURRENT MEDS AND/OR DIETARY SUPPLEMENTS: (Please also note what each med is used for!)

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→ CHECK OR "*X*" *THE BOX* IF YOU *HAVE HAD* THAT SYMPTOM *IN THE LAST 3 MONTHS*			
HEART PALPITATION		PROFUSE SWEATING	
INSOMNIA		DREAM DISTURBED SLEEP	
MENTAL CONFUSION		RESTLESSNESS	
PAIN IN CHEST		PAIN IN SHOULDER	
LACK OF JOY IN LIFE		UNCONTROLLABLE LAUGHTER	
CRAVING BITTER FOODS		AVOIDING BITTER FOODS	

→ CHECK OR "*X*" *THE BOX* IF YOU *HAVE HAD* THAT SYMPTOM *IN THE LAST 3 MONTHS*							
IS YOUR URINATION…							
FREQUENT		URGENT		DIFFICULT		PAINFUL	
SCANTY		CLEAR		YELLOW		REDDISH	
DO YOU HAVE:							
DRIBBLING AFTER URINATION				INCONTINENCE OF URINE			
BED WETTING				NOCTURNAL EMISSION			
IMPOTENCE				PREMATURE EJACULATION			
WEAKNESS OR PAIN IN LOWER BACK				WEAKNESS IN THE KNEES			
EDEMA IN THE LOWER LIMBS				NIGHT SWEATS			
POOR MEMORY				ASTHMATIC BREATHING			
DEAFNESS				RINGING IN THE EARS			
HAVE YOU BEEN OVERLY SCARED OR FEARFUL				WITHOUT FEAR			
CRAVING SALTY FOODS				AVOIDING SALTY FOODS			

→ CHECK OR "*X*" *THE BOX* IF YOU *HAVE HAD* THAT SYMPTOM *IN THE LAST 3 MONTHS*							
PAIN OR DISTENSION IN SIDES				BREASTS		LOWER ABDOMEN	
ITCHING OR PAIN OF THE EXTERNAL GENITALIA				SWELLING OR PAIN IN THE TESTIS			
MENTAL IRRITATION				MOOD SWINGS			
EXCESSIVE ANGER				FREQUENT HEADACHES			
FREQUENT MIGRAINES							
DO YOU HAVE / ARE YOUR EYES…							
RED		DRY		TIRED		ITCHY	
BLURRED VISION		MUSCLE SPASMS		TIGHT JOINTS		STIFF OR PAINFUL JOINT	
I HAVE BEEN CRAVING SOUR FOODS				I HAVE BEEN AVOIDING SOUR FOODS			

→ CHECK OR "*X*" *THE BOX* IF YOU *HAVE HAD* THAT SYMPTOM *IN THE LAST 3 MONTHS*							
IS YOUR THROAT…							
ITCHY		RED		SWOLLEN		PAINFUL	
DO YOU HAVE A COUGH				IS IT DRY		OR WITH SPUTUM	
FEVER				AND / OR CHILLS			
NASAL DISCHARGE				THIN AND WATERY		OR THICK	
SHORTNESS OF BREATH		EXCESSIVE PERSPIRATION		LACK OF PERSPIRATION		NIGHT SWEATS	
LACK OF STRENGTH				HOT (FEVERISH) PALMS OF HANDS AND SOLES OF FEET			
LOWER ABDOMINAL PAIN				DIARRHEA		AND / OR CONSTIPATION	
SKIN RASHES				DRY SKIN		OILY SKIN	
AN EXCESS OF GRIEF OR MELANCHOLY							
CRAVING OF PUNGENT FOOD				AVOIDING PUNGENT FOOD			

→ CHECK OR "*X*" *THE BOX* IF YOU *HAVE HAD* THAT SYMPTOM *IN THE LAST 3 MONTHS*							
RETENTION OF FOOD IN STOMACH / PROBLEMS DIGESTING				STOMACHACHE			
VOMITING				BELCHING			
HICCOUGH				FEELING HUNGER EASILY		NO APPETITE	
GUM PAIN		GUM SWELLING		GUM BLEEDING		BAD BREATH	
EDEMA		COLD EXTREMITIES		LOOSE WATERY STOOLS		PROLAPSE OF RECTUM	
PROLAPSE OF UTERUS		LASSITUDE		BRUISE EASILY		BLOOD IN STOOLS	
MUSCLES TIRED				OR WEAK		OR SORE	
BOTHERED BY TOO MUCH THINKING							
CRAVING SWEET FOODS				AVOIDING SWEET FOODS			