M D Y
Date / /

Confidential Vital Information

M D Y

Name__________________________ Age______ Gender: M □ F □ Date of Birth ____/____/____

Address__________________________ City__________________ Postal Code____________

Home Phone______________ Work Phone______________ Cell Phone_____________ Email _________________

Occupation__________________ How many hours/week do you work?_____

Marital Status (married, divorced, single, in relationship, etc.) ___________ Children/ages_________________

Physician_____________ Emergency Contact __________________ Relation ____________ Phone ______________

How did you hear about us?______________________________________

Primary Concern: ____

When did this first start (be specific)?_______________________________________
What makes it better? ____
What makes it worse? ____
What do you think is causing it? ____
____

If your concern is pain how would you rate it from 1 to 10 (10 the most intense, 0 none) ______
Is it constant or does it come and go?_____________________________________
How would you describe the pain—moving, changing, sharp, aching, tingling, etc.?______________________
Any other pains?____

Secondary Concerns: ____

When did this first start (be specific)? _____________________________________

Have you seen an MD for your current concerns?_______________ Do you have any lab or test results? _____

Do you currently see any other practitioners? ______________________________
If "yes", list the type and name of practitioners: ___________________________
Have you tried any other natural/alternative therapies for these concerns? ____________________
Did this treatment help you? ____

List ALL past surgeries____
List ALL past injuries ____
List ALL major illnesses ____

Current Medications ____
Past Medications ____
Current Supplements (and dosages) ____________________________________
____

Adverse Reactions to Medications or Vaccines ___________________________
List any allergies that you have to foods or other substances:_____________________

Your Past Medical History (Please check and date)

- ☐ Anemia
- ☐ Angina
- ☐ Anorexia/Bulemia
- ☐ Arthritis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Colitis or Chron's
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Fainting
- ☐ Gallstones
- ☐ Gout
- ☐ Hemophilia
- ☐ Heart Disease
- ☐ Pace maker
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ HIV
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Infection
- ☐ Kidney Problems
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ MS
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Prostate Conditions
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Stroke
- ☐ TB
- ☐ Ulcers
- ☐ Uterine Fibroids

Clarification on any of the above ____

Height_________ Weight_________

Please check all symptoms that apply to you now (check) or in the past (mark with P):

General

- □ Night sweats
- □ Sweat easily
- □ Fatigue
- □ Chills
- □ Weight gain
- □ Weight loss
- □ Change in appetite
- □ Bleed or bruise easily
- □ Sudden energy drop (time?)
- □ Peculiar tastes or smells
- □ Fevers

How would you describe your sleep?____

How would you describe your energy level? High ___ Moderate ___ Low ___ Up and down ___

Do you have an unusual susceptibility to heat or cold?______________________________

Do you prefer warmer or cooler climates? ____

Skin and Hair

- □ Rashes
- □ Itching
- □ Eczema
- □ Other hair or skin problems?
- □ Change in hair or skin texture
- □ Loss of hair
- □ Dandruff
- □ Recent moles
- □ Ulcerations
- □ Pimples

Head, Eyes, Ears, Nose and Throat

- □ Headaches
- □ Neck pain
- □ Concussions
- □ Eye pain
- □ Eyestrain
- □ Blurry vision
- □ Using glasses
- □ Night blindness
- □ Colour blindness
- □ Cataracts
- □ Earaches
- □ Poor hearing
- □ Ringing in ears
- □ Facial pain
- □ Sinus problems
- □ Nose bleeds
- □ Jaw clicks or pain
- □ Tooth pain
- □ "Silver" mercury tooth fillings
- □ Recurrent sore throats
- □ Sore on lips or tongue

Heart and Circulation

- □ High blood pressure
- □ Low blood pressure
- □ Irregular heart beat
- □ Fainting
- □ Chest pain
- □ Varicose veins
- □ Cold hands or feet
- □ Swelling of hands
- □ Swelling of feet
- □ Dizziness
- □ Blood clots

Lungs and Breathing

- □ Difficulty breathing
- □ Cough
- □ Bronchitis
- □ Asthma
- □ Pain with a deep breath
- □ Production of phlegm (color?)
- □ Coughing blood
- □ Pneumonia
- □ Other problems

Digestion and Elimination

□ Indigestion/Heart burn
□ Gas
□ Bloating
□ Abdominal pain or cramps
□ Nausea
□ Vomiting
□ Rectal pain
□ Hemorrhoids
□ Blood in stool
□ Bad breath
□ Constipation
□ Chronic laxative use
□ Diarrhea

How often do you have a bowel movement? ______ Quality? (formed, hard, soft, loose, etc.)________________________
Is your urinary frequency more than 6x/day or less than 4x/day?_________
Do you experience night time urination?_______ Number of times/night?____

Women

Are you Pregnant?_________ How many months?___________

____ Age of first menses
____ Length of menses
____ Length of menstrual cycle
____ Date of start of last menses
____ Date of last PAP exam
□ Unusual menses
□ Heavy
□ Light
□ Clots
□ Breast lumps
□ Irregular periods
□ Painful periods
□ Vaginal discharge
□ Vaginal sores

□ Do you perform a monthly self-breast exam?
□ Changes in your body or emotions prior to menstruation?________________________
□ Do you practice birth control? What type and for how long?_____________________
Number of pregnancies ____Number of births____ Miscarriages____ Abortions ____

Muscle, Joints and Bones

□ Neck pain
□ Back pain
□ Hip pain
□ Knee pain
□ Foot/ankle pain
□ Shoulder pain
□ Other joint or bone problems?
□ Hand/wrist pain
□ Muscle pain
□ Muscle Cramps

Brain, Nerve and Emotions

□ Loss of balance
□ Quick temper/irritable
□ Poor memory
□ Depression
□ Susceptible to stress
□ Dizziness
□ Concussion
□ Seizures
□ Areas of numbness
□ Anxiety
□ Lack of coordination
□ Nervousness

□ Have you ever been treated for emotional problems?
□ Any other neurological or psychological problems?

Stress

Current Stress Level 1 to 10 (10 being highest, 0 being no stress) At Work____ At Home_____ Other ______
How long have you felt like this? At Work______________ At Home_____________ Other __________________

What would you describe as the three dominant emotions in your life at this time? (Examples include Happiness, Fear, Sadness, Anxiety, Frustration, Anger, Grief, Heartache, Contentment, Excitement, Lethargic, Moody, Stressed, and so forth:____

Family History

Please list the state of health and major illnesses that members of your family have had.
If relevant, include at what age they died (and what they died of).

Father: ____
Father's mother:____
Father's father:____

Mother:____
Mother's mother:____
Mother's father:____

Brothers and Sisters:____
Your children:____
Other family information:____

Write down the number of hours (to the half hour) per day you spend sedentary (either lying or sitting down) in each of the following:

Lying in bed (including sleep) ______
Sitting in transit ______
Sitting at work ______
On the couch ______
At the home computer ______
Sitting eating meals ______
Other ______
Total sedentary hrs per day: ______

Do you exercise?_____ List type and how often____

Habits

How much coffee do you drink per week?_________
How much alcohol do you drink per week? _______
How much pop do you drink per week? __________
Do you smoke?____ How much per day?_________
Recreational drugs? ______ Type and how often?__________

Food and Diet

How is your appetite? ___ low ___ moderate ___ high
How is your thirst? ___ low ___ moderate ___ high
Are there any foods/drinks that you crave? ____
Are there any foods/drinks that you are strongly averse to? _________________________________
Do you follow a specific diet? (Example: vegetarian, gluten free, macrobiotic, meat & potatoes, etc.)_________________
Do you generally cook your own food? _____________________________

Please describe your general diet:

Breakfasts:
Lunches:
Dinners:
Snacks:
Drinks:

Please fill in the chart indicating how often you consume the following foods:

F - Frequently consume (daily or more)
R – Regularly consume (a few times a week)
S – Sometimes consume (generally less than once a week)
N – Never or very rarely consume

___ Beans	___ Fast Food	___ Milk	___ Salad or Raw Vegetables	___vegetables
___ Beef	___ Fish / Seafood	___ Nuts & Seeds	___ Soda or Energy Drinks	
___ Bread	___ Fried Foods	___ Nut Butters	___ Soy Products	
___ Cheese	___ Fruit	___ Pasta	___ Sweets / Pastries	
___ Chicken	___ Grains	___ Potatoes	___ Turkey	
___ Chips	___ Juice	___ Pork/Ham	___ Yogurt or Kefir	
___ Eggs	___ Ice Cream	___ Eat Out	___ Frozen Prepared Foods	

Blood Type (if known)_________

If there is anything you would like to add, please feel free to do so. If you have any questions or concerns you would like addressed, you may write them here.

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