MEDICATIONS TAKEN

Current Medications. including vitamins, over-the-counter medications. and intermittently-used drugs.

NAME	STRENGTH	HOW OFTEN TAKEN	PURPOSE	WHEN USE STARTED	REQ.	AS NEEDED

Are you allergic to any medicine or foods? ☐ Yes ☐ No

Please list_____

_____

LIST ANY MAJOR ILLNESSES

ILLNESS	DATE	TREATMENT	OUTCOME

LIST ANY SURGERIES

SURGERY	DATE	REASON

Have you ever had surgery to aid in weight loss? ☐ Yes ☐ No If yes, when?_____

Pt. Name:_____

FAMILY HISTORY

✓ CHECK ALL THAT APPLIES

Family Member	Age now or at Death	Cause of Death	Thin	Normal Weight	Slightly Overweight	Moderately Overweight	Markedly Overweight	Health Problems

What other family members are obese (indicate mother's / father's side of the family).

_____

_____

What other family members have or have had:

Breast, Colon or Prostrate Cancer? _____

_____

Cancer (specify type): _____

_____

Diabetes: _____

_____

Heart attack: _____

_____

Stroke: _____

High blood pressure: _____

_____

Arthritis: _____

Back trouble: _____

SHORTNESS OF BREATH

Do you experience shortness of breath with physical activity? ☐ Yes ☐ No

How long have you been aware of this (be specific)? _____ Months _____ Years

When walking up stairs, how many steps can you climb before noticing shortness of breath?
_____ steps/flights. (Please circle one and indicate how many).

Pt. Name: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, complete the following:

What type of exercise:_____ How often?_____

What prevents you from exercising now?_____

In what position do you sleep? ☐ Sitting up ☐ Lying flat on back ☐ Lying on side ☐ Lying on stomach

How many pillows do you use under your head?_____ Do you awaken from sleep to catch your breath?_____

Do you snore? ☐ Yes ☐ No Do you ever stop breathing while asleep? ☐ Yes ☐ No

Do you doze off when you're talking to someone? ☐ Yes ☐ No

Have you ever had a sleep study done? ☐ Yes ☐ No

Do you have or have had asthma? ☐ Yes ☐ No How long?_____

Do you experience swelling of the ankles? ☐ Yes ☐ No How long?_____

What do you do to decrease the swelling?_____

Do you experience chest pain with exercise or activity? ☐ Yes ☐ No How long?_____ (yrs / mos)

What do you take to relieve the pain?_____

Thyroid problems? ☐ Yes ☐ No Describe:_____

Are you Diabetic? ☐ Yes ☐ No How long?_____ What are you taking for diabetes?_____

Do you monitor your blood sugar? ☐ Yes ☐ No How often?_____

Do you have high blood pressure? ☐ Yes ☐ No How long?_____

What are you taking for your high blood pressure?_____

HEARTBURN AND/OR INDIGESTION

Do you have indigestion or heartburn? ☐ Yes ☐ No If so, for how long_____ years / months

What food or drinks cause digestive problems for you?_____

Do you ever have any type of pain in the abdomen? ☐ Yes ☐ No If yes, give details:_____

_____

Indicate on the picture the location

Type of pain (sharp, dull, hot, cold, aching, crushing, etc.)_____ What foods or drinks, (if any) cause the pain?_____

When does the pain begin (before, during or after eating; give the amount of time)_____

☐ Before ☐ During ☐ After eating

How long does it last?_____ How often does this happen?_____

What relieves the pain?_____ What have you tried that did not relieve the pain?_____

Any changes in bowel movements? ☐ Yes ☐ No Explain:_____

Any bloody stools? ☐ Yes ☐ No History of hemorrhoids? ☐ Yes ☐ No External / Internal

BONE OR JOINT PROBLEMS

Do you have any of the following:

LOCATIONS	SWELLING	PAIN	STIFFNESS	POPPING
ANKLES				
KNEES				
HIPS				
BACK				
OTHER				

Have you ever sought treatment for bone or joint problems or injuries? Give details. (Include physical therapy and chiropractic)

Doctor	Date of Treatment	Diagnosis/Treatment

Have you taken any medications for this problem? If so what?_____

Have you consulted a chiropractor? ☐ Yes ☐ No

Have you ever been told you have degenerative changes or early arthritic changes in your joints? ☐ Yes ☐ No

URINARY PROBLEMS (Females)

Do you ever involuntarily lose your urine? ☐ Yes ☐ No

If yes, what causes you to lose urine? ☐ Coughing ☐ Jumping ☐ Sneezing ☐ Walking ☐ Bending forward ☐ Laughing

Do you experience pain when urinating? ☐ Yes ☐ No

Do you wear pads for protection? ☐ Yes ☐ No How often must you change pads?_____

How often do you wet your clothing?_____ Any history of bladder surgery? ☐ Yes ☐ No

Pt. Name:_____

FEMALES ONLY

At what age did your periods start?_____

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age?_____

Are your periods: ☐ Regular ☐ Irregular Is the flow during your period heavy? ☐ Yes ☐ No

What was the date of your last menustral period?_____ Any cramping? ☐ Yes ☐ No

Spotting between menstrual period? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No If yes, how many children?_____

Any miscarriages? ☐ Yes ☐ No How many?_____

Last Pap smear_____ Was it normal? ☐ Yes ☐ No Last mammogram?_____

PSYCHIATRIC HISTORY

Psychiatric Treatment? Treated By: ☐Psychiatrist ☐Therapist ☐Psychologist ☐Physician

Hospitalization? ☐ Yes ☐ No

When was your treatment?_____ Where?_____

How long have you been in treatment?_____

Current medications & dosages:_____

Diagnosis & reason for treatment:_____

Are you presently married? ☐ Yes ☐ No How Long?_____

Is this your first marriage? ☐ Yes ☐ No If no, how many previous marriages?_____

On a scale of 1 to 5 (1= least happy), how would you rate your current marriage?_____

Are you currently employed? ☐ Yes ☐ No If yes, how long have you been employed?_____

On a scale of 1 to 5 (1= least happy), how happy are you with your present job?_____

On a scale of 1 to 5 (1 = least satisfied), how would you rate overall satisfaction with yourself?_____

Pt. Name:_____

REVIEW OF SYMPTOMS

UNLESS OTHERWISE SPECIFIED. ANSWER THE FOLLOWING REFERRING TO YOUR CURRENT STATUS.

	NO	YES	DETAILS OR COMMENTS
Frequent or severe fatigue			
Frequent or severe weakness			
Fever, chills, or nightsweats			
Frequent or severe headaches			
Any history or head injury with loss of consciousness			
Nasal congestion			
Chronic sinus congestion			
Wheezing			
Coughing			
Heart murmur			
Anemia			
Any history of blood transfusion			
Bleeding tendency			
Convulsions, seizures			
Paralysis			
Numbness or tingling			
Memory loss			
Depression			
Anxiety			
Mood swings			
Sleep problems			
Drug or alcohol abuse			
Chronic skin rash or hives			
Hay fever			

Have you used tobacco products in the past? ☐ Yes ☐ No If yes, how long?_____

Do you now use any tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes or packs per day?_____

Do you ever drink alcohol? ☐ Yes ☐ No

If yes, what beverages?_____ How many drinks per day?_____

Do you use caffeine? (Coffee, cocoa colas, chocolates, No-Doz, Aqua Ban). ☐ Yes ☐ No

If yes, in what form?_____

How much per day?_____

Pt. Name:_____