PATIENT INFORMATION FORM

Name_____
Age _____ M / F (circle)

In your own words describe your chief complaint _____
_____
_____

Please check any symptoms that apply to you now or in the last 3 months.

Part A:
cough___
phlegm___
wheezing___
short of breath___
hoarseness___
sneezing___
loss of smell___
nasal congestion___
nasal discharge___
asthma___
allergies___
hay fever___
itching eyes___
sinus headaches___
acne___
perspire easily___
itchy skin___
swollen glands___
vocal problems___
sore throats___
painful lymph nodes___
dry skin___
dry brittle hair___
smoker___
fatigues after perspiring___
catch colds easily___
grief___
melancholy- sadness___
crave spicy foods___
dislike dry weather___
dislike wind___
dislike damp weather___

Part B:
drooping eyelid___
prolapsed uterus___
prolapsed stomach___
gums bleed easily___
nose bleeds___
appetite - high___ low___
diarrhea___
loose stool___
bowel movements per day___#
heartburn___
constipation___
ulcers___
stomach pain___
gas___
intestinal rumbling___
alternating constipation & diarrhea___
butterfly sensation in stomach___
bad breath___
poor short term memory___
poor long term memory___
inability to concentrate___
known food allergies
_____
_____
loss of taste___
crave sweets___
chocolate especially___
cookies - cakes___
bruise easily___
slow wound healing___
poor digestion___
abdominal bloating___
fatigue after eating___
discomfort after eating___
nausea___
vomiting___
belching - burping___
flatulence___
hemorrhoids___
hernia___

Part C:
headache___
  where on your head_____
migraine___
tight or constricted chest___
anger easily___
pains increase with stress___
clear throat often___
high blood pressure____
  last reading ____/____
acid regurgitation___
vertigo___
eyes red___
yellow eyes/skin___
spots before eyes___
hiccups___
irritable___
lower rib pain___
bitter taste in mouth___
depression___
frustration___
sensation of something in throat___
Premenstrual symptoms___

describe_____
_____
dizziness___
eyes tired___
eyes sensitive___
blurred vision___
eyes sore___
high cholesterol___
high triglycerides___
history of hepatits___

Part D: Women Only
age at first period___
age of menopause___
painful menses___
cycle (ie. every 28 days)___
irregular cycle___
length of flow (ie. 4-7 days)___
clots___
cramps later in flow___
recent change in cycle___
history of vaginal warts___
vaginal pain___
irregular pap test___
breast distension___
breasts painful___
fibroid tumors___
fibrocystic breast/ovary___
cramps early in flow___
Color of flow: dark__light__bright__
# of pregnancy___
miscarriages___
infertility___
gyn surgeries_____
_____
date of last period___/___/___
regular breast exam or mammogram___

Part E:
fatigue____
  slump time of day____ am/pm
awakens fatigued___
cold feet___
cold hands___
urine color: dark___ light___ clear___
urination daily:
        4-6 times___
        6-10 times___
        10+ times___
night urination___
decreased stream or amount___
urgent urination___
painful urination___
ear ringing___ high___ low___
hearing loss___
dark circles___
weak/sore knees___
rheumatoid arthritis___
hair loss___
impotence___
chronic urinary infections___
intolerant of cold___
history if Kidney infection___
joints stiff___
difficulty breathing___
fear___
anxiety___
morning diarrhea___
excess energy___
sex drive-high___ low___ normal___

incontinence___
difficult urination___
burning/painful urination___
swelling ankles___
puffy beneath eyes___
lower back pain___
loss teeth___
osteoarthritis___
infertility____
spermatorrhea___
abnormal thirst___
craves salt___
history of kidney stones___
joints painful___
pains get worse with exercise___
phobias___
asthma___
seminal emission___
memory loss___

Part F:
Palpitations (feeling of heart beating, racing, or skipping beats) ___
speech problems___
delirium___
jittery___
sweat at night___
hot palms___
insomnia___
pale skin___
missed pulse beats___
feeling of impending doom___
dry mouth___
chest pain___
restlessness___
irritability___
short of breath___
flushing in afternoon___
numb hands___
sore tongue___
mouth sores___
heart murmur___
chest congested___
scanty, yellow urine___
racing heart beat___

Part G:
sense of heaviness___
favor warm drinks___
favorite color___
physical labor___
muscle cramps___
fever/chills___
brittle nails___
favors cold drinks___
sedentary work___
regular exercise___
twitches/spasms___
weakness___

Part H: Please Circle What Applies to You
Medications:
Antacids
Antidepressants
Antibiotic/Antifungal
Glucose Regulator/Insulin
Anti-inflammatory
Aspirin/Tylenol/Advil
Chemotherapy
Heart Medications
High Blood Pressure Rx
Hormones
Laxatives
Oral Contraceptives
Radiation
Recreational Drugs
Thyroid
Relaxants/Sleeping Pills
Ulcer Medications
Other_____

Do You Eat, Drink or Use (Circle/explain):
Alcohol
Coffee
Decaf
Candy
Cigarettes
Carbonated Beverages
Diet Sodas
Distilled Water
Fried Foods
Fast foods, regularly

Refined sugars
Red meat, regularly
Margarine
Vitamins_____
_____
_____
Minerals_____
_____
_____
Herbs_____
_____
Homeopathics_____

Check if you:
diet often___
exercise___
salt foods w/o tasting___
are under excessive stress___
exposed to chemicals___
work at a computer___

Check any you have had:
appendicitis___
scarlet fever___
typhoid fever___
HIV___
Rheumatic fever___
nephritis____
malaria___
anemia___
mumps___
measles___
small pox___
eczema___
diabetes___
diptheria___
heart disease___
pneumonia___
polio___
jaundice___
hearing loss___
tuberculosis___
herpes___
tonsillectomy___
hepatitis___
epilepsy___
obesity___
asthma___
cancer___
heart attack___
goiter___
influenza___
pleurisy___
meningitis___
chemical poisoning___
drug reaction___
allergic reaction___
whooping cough___
alcoholism___
mental disorders___
eating disorders___
venereal infection___

Anything else you would like us to be aware of?
_____
_____
_____

Family History of: (list who)
Stroke_____
Heart Disease_____
Cancer (who & what kinds)
_____
_____
Diabetes_____
Mental Disorders_____
Gallbladder Disease_____
Thyroid Disease_____
Alzheimer's_____
Neurologic Disease_____

Emotional Status

Emotional Scale: (circle # how you feel usually)

Depressed 5-4-3-2-1-**0**-1-2-3-4-5 **Anxious**

Sleep Pattern

How many hours do you sleep nightly? ___ Hrs.

Please provide what a typical day would like. Record all the foods you eat and drink. Be sure to include the approximate amount of each food. When you have completed this booklet, return it to your healthcare practitioner for evaluation. ***Your diet may be the key to better health.***

Current Typical Daily Diet

BREAKFAST	***LUNCH***	***DINNER***
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Veggies & Fruit
Breads, cereal, grains	Breads, cereal, grains	Breads, cereal, grains
Fats (butter, margarine, oils, etc)	Fats (butter, margarine, oils, etc)	Fats (butter, margarine, oils,)
Candy, Sweets & Junk food	Candy, Sweets & Junk food	Candy, Sweets & Junk food
Drinks	Drinks	Drinks

MID-MORNING SNACK:	***MID-AFTERNOON SNACK:***	***NIGHTTIME SNACK:***