



wholebody solutions

nutrition • chiropractic • acupuncture • brain integration

Note: Information provided on this form is confidential. Please take a moment to complete the form in detail.

Please PRINT

Today's Date ___/___/___

Name: _____ Date of Birth: ___/___/___ Age: _____ Sex: Male Female

Street Address _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____

Preferred Method of Communication for Patient Reminders (Circle One): Phone Email Text

Your occupation _____ # of hours you work per day _____ and week _____

Email: _____

Height _____ Weight _____ Has your weight fluctuated greatly in the past 3 years? _____

Race: American Indian or Alaska Native Asian Black or African American White (Caucasian)

Native Hawaiian or Pacific Islander Other I Decline to Answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino I Decline to Answer

Status: Single Married Divorced Separated Live with partner

Emergency Contact / Relationship: _____ Tel: _____

Primary Physician: _____ Physician's Phone: _____

Smoking Status: Everyday Smoker Occasional Smoker Former Smoker Never Smoked

CURRENT HEALTH

What are the main symptoms/problems for which you are seeking treatment?

1. _____

How long have you had this? _____ The on-set was: Sudden Gradual

What diagnosis / treatment have you received? _____

2. _____

How long have you had this? _____ The on-set was: Sudden Gradual

What diagnosis / treatment have you received? _____

Please list any previous surgeries, hospitalizations and serious illnesses with dates:

Please list below all of the medications/supplements/herbs you take:

<u>Medication/Supplement/Herb</u>	<u>Dose</u>	<u>Reason for Taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any medication allergies?

List Here:

Diet Please give a general description of the food you eat during a "typical" day.

Morning:

Afternoon:

Evening:

Before bed:

Between meals:

WESTERN MEDICAL DIAGNOSIS

Please check off any Western Diagnosis you have now or have had in the past:

- AIDS/HIV Alcoholism Joint replacement Asthma Pacemaker
- Hepatitis B Drug Addiction Multiple sclerosis Diabetes Stroke
- Hepatitis C Anxiety Chronic fatigue syndrome Arthritis Heart attack
- TB Depression Fibromyalgia Lyme disease Epilepsy/seizures
- Cancer: type: _____ current status: _____
- Allergies: what drugs or substances (plant, animal, environmental) _____

What are Your Treatment Goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

DIAGNOSTIC QUESTIONS

Please indicate which symptoms below you have experienced **within the past 3 months**. **Please circle according to the severity of your symptoms: L=Light M=Medium S=Strong** (Leave blank if you do not have the symptom.)

HEAD,

L M S headaches- where are the headaches: Side, Top, Back or Front of head; How often _____

L M S sinus infections L M S grind teeth L M S dizziness/vertigo

L M S sinus pressure L M S jaw pain

L M S thrush/leukoplakia L M S migraines

EYES, EARS, NOSE, THROAT

L M S runny nose L M S nasal congestion L M S nose bleeds

L M S vision problems L M S floaters in eyes L M S dry/itchy eyes

L M S ringing in ears L M S difficulty hearing L M S ear aches

L M S bleeding gums L M S sores in mouth L M S dry mouth L M S thirst

L M S difficulty swallowing L M S sore throat L M S other: _____

SKIN/HAIR/NAILS

L M S itchy/painful rashes L M S fungus L M S cold sores L M S spider veins
 L M S psoriasis/eczema L M S shingles L M S acne L M S dry skin
 L M S bleed/bruise easily L M S hair loss L M S mole changes L M S other: _____

RESPIRATORY

L M S shortness of breath L M S phlegm L M S pain w/deep breath L M S bronchitis
 L M S coughing up blood L M S wheezing L M S chronic cough L M S tightness in chest
 L M S asthma L M S other _____

CARDIOVASCULAR

L M S low blood pressure L M S chest pain L M S high cholesterol
 L M S high blood pressure L M S palpitations L M S other: _____

GASTROINTESTINAL

L M S loss of appetite L M S weight loss L M S abdominal pain L M S insatiable hunger
 L M S vomiting L M S gas/bloating L M S belching L M S burning sensation
 L M S heartburn L M S ulcers L M S other: _____

STOOLS

L M S diarrhea L M S loose stools L M S constipation L M S blood in stool
 L M S mucus in stool L M S urgency L M S cramping with BM L M S hemorrhoids

GENITALS / URINARY

L M S frequent urination L M S night urination L M S impotence L M S incontinence
 L M S painful urination L M S kidney stones L M S low sex drive L M S dribble if sneeze or cough
 L M S urinary track infections L M S blood in urine L M S genital warts/sores L M S other: _____
 Average color of urine (ignore first urination of day): pale medium yellow dark yellow

MUSCULAR / SKELETAL / NEUROLOGICAL

L M S muscle/joint pain L M S back pain L M S stiff neck/shoulder L M S weakness
 L M S tremors L M S seizures L M S leg cramps L M S restless leg
 L M S tingling, numbness or pain in arms, fingers, legs or toes (neuropathy) L M S other _____

SLEEP

L M S trouble falling asleep L M S trouble staying asleep L M S disturbing dreams
 L M S trouble falling back asleep L M S restless sleep L M S wake feeling unrested

PSYCHOLOGICAL / EMOTIONAL

L M S irritability/anger L M S depression L M S disorientation L M S substance abuse
 L M S forgetfulness L M S anxiety L M S worry L M S bipolar
 L M S poor concentration L M S schizophrenia L M S other _____

WHOLE BODY SYMPTOMS

L M S swollen lymph nodes L M S night sweats L M S fatigue L M S frequent colds
 L M S glucose intolerance L M S day sweats L M S chills L M S other _____

GYNECOLOGICAL/OBSTETRICS

L M S yeast infections L M S clots L M S mid-cycle pain L M S vaginal pain/itching
L M S pelvic infections L M S no periods L M S PMS L M S vaginal discharge
L M S menstrual cramps L M S spotting L M S irregular periods L M S Other _____
L M S hot flashes L M S night sweats L M S fibroids

Menstrual Info: age of first period _____ days of bleeding _____ days of cycle _____ date of last period _____

Do you take Hormone Replacement Therapy? Yes No

Are you pregnant? Yes No Unknown Are you presently trying to get pregnant? Yes No

(Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy).

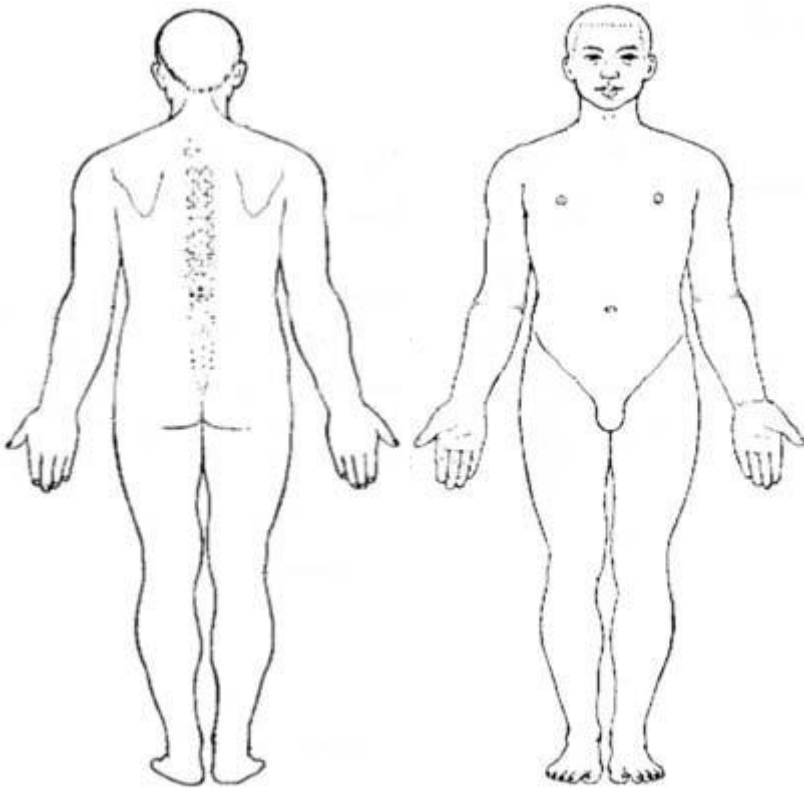
Are you in menopause? Yes No Unknown

How many pregnancies have you had? _____ # of births _____ # of Cesareans _____ # of children _____

Date last pap smear _____ NORMAL ABNORMAL

Last breast exam _____ NORMAL ABNORMAL

Indicate Painful or Distressed Areas



Patient Signature: _____ **Date:** _____