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: O Male O 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: O American Indian or Alaska Native O Asian O Black or African American O White (Caucasian)
O Native Hawaiian or Pacific Islander O Other O I Decline to Answer

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

Status: O Single O Married O Divorced O Separated O Live with partner

Emergency Contact / Relationship:_____ Tel: _____

Primary Physician:_____ Physician's Phone: _____

Smoking Status: O Everyday Smoker O Occasional Smoker O Former Smoker O 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: O Sudden O Gradual

What diagnosis / treatment have you received? _____

2._____

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

Medication/Supplement/Herb	Dose	Reason for Taking

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:

O AIDS/HIV	O Alcoholism	O Joint replacement	O Asthma	O Pacemaker
O Hepatitis B	O Drug Addiction	O Multiple sclerosis	O Diabetes	O Stroke
O Hepatitis C	O Anxiety	O Chronic fatigue syndrome	O Arthritis	O Heart attack
O TB	O Depression	O Fibromyalgia	O Lyme disease	O Epilepsy/seizures

O Cancer: type: _____ current status: _____

O 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? O Yes O No

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

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

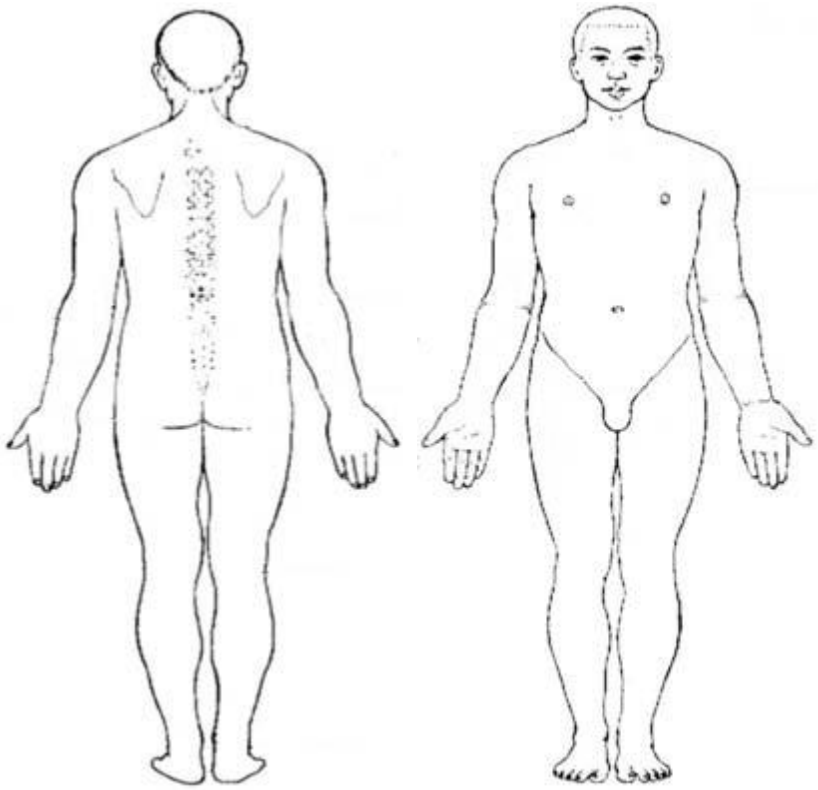
Are you in menopause? O Yes O No O Unknown

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:** _____