Name: _____ Date: _____

Please circle the following
Y: A condition that you have now
P: A condition that you have had in the past
N: A condition that you have never had

**Please leave anything you don't care to discuss blank. I find all of this information is relevant but I realize not everyone is ready to discuss sensitive matters. Should such matters exist, I hope that we can work together to eventually discuss them as repression can be the root of many manifestations.*

1. General	
Weight	Recent weight change? Y N
Weight one year ago	Goal weight:
Maximum weight and when	
Height	
Waist size	

2. Systemic				Additional Comments
Fatigue	Y	P	N	
Weakness	Y	P	N	
Fever	Y	P	N	
Chills	Y	P	N	
Night sweats	Y	P	N	

3. Skin				
Rashes	Y	P	N	
Eczema/psoriasis	Y	P	N	
Hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Colour change	Y	P	N	
Lumps	Y	P	N	
Dryness	Y	P	N	
Moistness	Y	P	N	
Cracked heels	Y	P	N	
Nail changes	Y	P	N	
Change in mole	Y	P	N	
Skin cancer	Y	P	N	
Anything peculiar	Y	P	N	
Cellulite	Y	P	N	

4. Head				
Headaches	Y	P	N	

Head injury	Y	P	N	
Anything peculiar	Y	P	N	

5. Eyes				
Impaired vision	Y	P	N	
Glasses/contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing	Y	P	N	
Dryness	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	
Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	
Floaters	Y	P	N	
Anything peculiar				

6. Ears				
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Discharge	Y	P	N	
Ringing	Y	P	N	
Infections	Y	P	N	
Dizziness	Y	P	N	

7. Nose and Sinuses				
Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stuffiness	Y	P	N	
Hay fever	Y	P	N	
Deviated septum	Y	P	N	

8. Mouth and Throat				
Frequent sore throat	Y	P	N	
Swollen tonsils	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	

Loss of taste	Y	P	N	
Adult teeth falling out/decaying	Y	P	N	
Cold sores	Y	P	N	
Fillings	Y	P	N	
Anything peculiar	Y	P	N	

9. Neck				
Lumps	Y	P	N	
Swollen glands	Y	P	N	
Goiter	Y	P	N	
Pain or stiffness	Y	P	N	
Difficulty swallowing	Y	P	N	
Anything peculiar				

10. Respiratory				
Cough	Y	P	N	
Phlegm	Y	P	N	
Spitting up blood	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Pleurisy	Y	P	N	
Emphysema	Y	P	N	
Difficulty breathing	Y	P	N	
Pain on Breathing	Y	P	N	
Shortness of Breath	Y	P	N	
Shortness of Breath at night	Y	P	N	
Shortness of breath lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest x-ray				

11. Cardiovascular				
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Low blood pressure	Y	P	N	
High cholesterol	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	

Palpitations, fluttering	Y	P	N	
Cyanosis (Blue skin)	Y	P	N	
Past ECG	Y	P	N	
Other heart tests				

12. Breasts				
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain or tenderness	Y	P	N	
Nipple Discharge	Y	P	N	
Inverted nipples	Y	P	N	
Recent changes	Y	P	N	
Anything peculiar	Y	P	N	

13. Digestion				
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
# of bowel movements per day				
Is this a change?	Y		N	
Blood in stool	Y	P	N	
Mucous in stool	Y	P	N	
Undigested food in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Bloating	Y	P	N	
Jaundice	Y	P	N	
Liver disease	Y	P	N	
Gall bladder disease	Y	P	N	
Ulcer	Y	P	N	
Indigestion	Y	P	N	
Constipation	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Any recent changes?	Y		N	
Anything peculiar	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	
Hernias	Y	P	N	

H. pylori	Y	P	N	
Do you need to strain to defecate?	Y	P	N	
Anything peculiar	Y	P	N	

14. Urinary				
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	
Flank pain	Y	P	N	
Anything peculiar	Y	P	N	

15. Male reproductive				
Hernias	Y	P	N	
Testicular mass	Y	P	N	
Testicular pain	Y	P	N	
Sexually active	Y	P	N	
Low libido (sex drive)	Y	P	N	
Sexual difficulties	Y	P	N	
Sexually transmitted infection	Y	P	N	
Discharge or sores	Y	P	N	
Lesions on penis	Y	P	N	
Urethra pain	Y	P	N	
Troublesome breast tissue	Y	P	N	
Anything peculiar	Y	P	N	
Do you do self-exams?	Y	P	N	

16. Female reproductive				
Age menstruation began	Y	P	N	
Average # of days	Y	P	N	
Length of cycle	Y	P	N	
Bleeding between periods	Y	P	N	
Irregular cycles	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
Clots	Y	P	N	
PMS	Y	P	N	

Breast tenderness	Y	P	N	
Birth control	Y	P	N	Type:
Difficulty conceiving	Y	P	N	
Sexually active	Y	P	N	
Low libido (sex drive)	Y	P	N	
Sexual difficulties	Y	P	N	
Sexually transmitted infections	Y	P	N	
Last menstrual period	Y	P	N	
Yeast infection	Y	P	N	
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Last PAP (date/result)				
Anything peculiar				

17. Musculoskeletal				
Joint pain or stiffness	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Heel pain	Y	P	N	
Weakness	Y	P	N	
Joint swelling	Y	P	N	
Hip pain	Y	P	N	
Backache	Y	P	N	
Anything peculiar				

18. Peripheral vascular				
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Thrombophlebitis	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	
Anything peculiar	Y	P	N	

19. Neurologic				
Fainting	Y	P	N	
Seizures/convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	

Numbness/tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Tremor	Y	P	N	
Speech problems	Y	P	N	
Anything peculiar	Y	P	N	

20. Endocrine (Hormonal)				
Heat or cold intolerance	Y	P	N	
Thyroid issues	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	
Hormone therapy	Y	P	N	
Low cholesterol	Y	P	N	
Anything peculiar				

21. Blood/lymphatic				
Anemia	Y	P	N	
Easy bleeding/bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

22. Allergic history				
Drug sensitivity	Y	P	N	
Hives	Y	P	N	
Reaction to vaccine	Y	P	N	
Please list any allergies (food, seasonal, etc…)				

23. Emotional				
Depression	Y	P	N	
Suicidal	Y	P	N	
Mood swings	Y	P	N	
Anxiety/nervousness	Y	P	N	
Tension/irritability	Y	P	N	

Phobias	Y	P	N	
Alcohol/drug abuse	Y	P	N	
Any addiction	Y	P	N	
Insomnia	Y	P	N	
Excessive crying	Y	P	N	
Hopelessness	Y	P	N	
Worthlessness	Y	P	N	
Boredom	Y	P	N	
High stressful situation	Y	P	N	
Abusive relationship (verbal or physical)	Y	P	N	
Bullying or being Bullied	Y	P	N	

24. Hobbies/habits			
How many meals per day?			
Do you wake rested?	Y	N	
Do you sleep well?	Y	N	
# of hours of sleep on average?			
Do you enjoy your work	Y	N	
# of hours of TV per day			
Do you read?	Y	N	
Do you exercise?	Y	N	
What forms?			
How often?			
Do you take vacations?	Y	N	
Do you use recreational drugs?	Y	N	
Do you drink alcohol?	Y	N	
What are your main interests and hobbies			
What do you enjoy?			
Which emotion is most common?			

25. **Other**	
Would you like to see our chiropractor?	
Would you like to see our Massage Therapist?	
Religious background (if any)	
Any other symptoms or anything important that was not covered?	