

Nature's Restorative Health

Thank you for taking the time to fill this out carefully. Though some questions might seem irrelevant to your condition, every piece of information helps to form a complete picture of your overall health. Holistic medicine treats the whole person, not just disease. All information will be confidential. If you have any questions, please ask.

Patient Information

First _____ Last _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Birth Date _____

Email Address: _____

Emergency Contact: _____ Phone Number _____

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Main problem(s):

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment(s) have you tried? _____

What makes it worse? _____ What makes it better? _____

Please rate your current pain or discomfort on a scale of 1 – 10:
 Very slight 1 2 3 4 5 6 7 8 9 10 Unbearable

Is there anyone in your family with the same/similar problems?

Medical History: (Please include the mo/yr when the event occurred or when the diagnosis was established)

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Diabetes			High blood pressure		
HIV/AIDS			Seizures			Heart Disease		
Hepatitis (what type)			Thyroid disease			High cholesterol		
Anemia			Tuberculosis			Breathing problems		
Arthritis			Digestive disorders			Alcohol/drug addiction		
Emotional disorders			Depression or anxiety			Other		

Surgeries: _____ Hospitalization: _____

Significant trauma: (auto accidents, sports injuries, etc)

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and dosages):

Allergies: (drugs, chemicals, foods, environmental):

Personal Gender _____ Age _____ Height _____ Weight _____

Weight one year ago _____ Maximum weight _____

Occupation: _____ Occupational stress (chemical, physical, psychological, etc.) _____ Do you work indoors or outdoors? _____

Daily Routines

Do you smoke? Yes No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes _____

How many hours do you sleep in general? _____ When do you usually go to bed? _____

Do you exercise regularly? Yes No What kind of exercise? _____

Diet

How much coffee do you drink? _____ cups/day; soft drinks _____ /day; tea _____ /day; water _____ /day

What kind of alcoholic beverages do you usually drink, if any? _____ Avg number of drinks/wk?

Are you a vegetarian? Yes No Yes, but not strict Do you eat a lot of spicy food? Yes No

What kind of food cravings do you have? _____

Please describe your average daily diet (Please be as specific as possible):

Morning _____

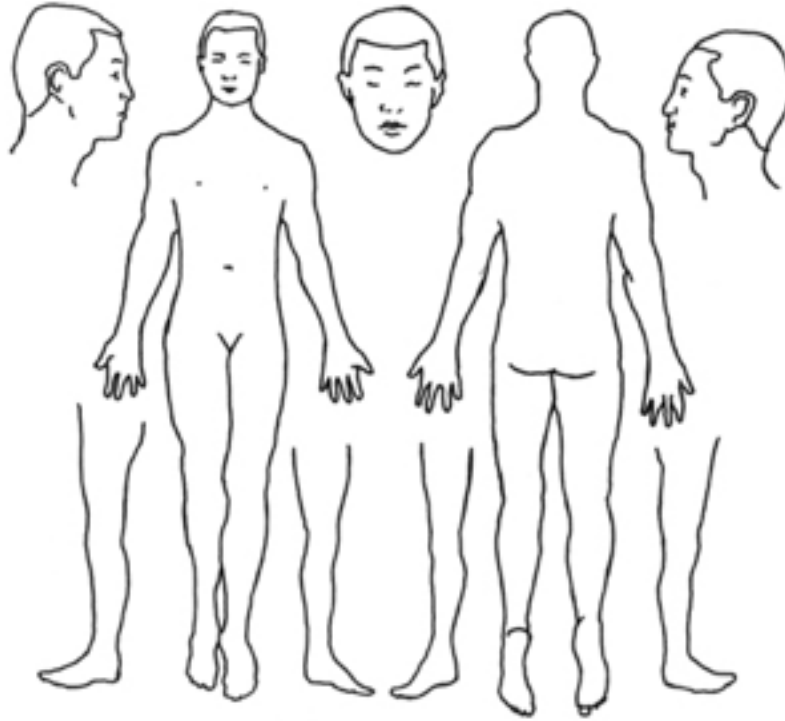
Afternoon _____

Evening _____

Snacks _____

Remarks and additional information regarding diet _____

Indicate painful or distressed areas:



Signs & Symptoms: Please check any of the following that applies to you now or in the past 6 months.

General

- Poor appetite Poor sleeping Fatigue Fever Chills
- Night Sweats Sweat easily Tremors Cravings Change in appetite
- Poor balance Bleed easily Bruise easily Localized weakness Weight loss/gain
- Peculiar tastes Desire hot food Desire cold food Strong thirst (cold or hot drinks)
- Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & Hair

- Rashes Ulcerations Hives Itching Eczema
- Pimples Dandruff Dry skin Recent moles Loss of hair Purpura
- Change in hair or skin texture Other? _____

Musculoskeletal

- Joint disorders Muscle weakness Muscle pain/soreness Tremors
- Difficult walking Cold hands/feet Swelling of hands/feet Back pain Scoliosis
- Hernia Numbness Tingling Paralysis Neck tightness/pain
- Shoulder pain Hand/wrist pain Hip pain Knee pain Joint sprain Other _____

Head, Eyes, Ears, Nose, Throat

- Eye strain Eye pain Color blindness Night blindness Poor vision Cataracts
- Blurry vision Earaches Ringing in ears Poor hearing Spots/floater in vision
- Sinus problems Nose bleeding Sore throat Grinding teeth Teeth problems Facial pain
- Jaw clicks/TMJ Sores on lips/tongue Difficulty swallowing Other

Cardiovascular High Blood Pressure Low Blood Pressure Chest pain Palpitations

- Fainting Phlebitis Irregular heartbeat Rapid heartbeat Varicose veins Other

Respiratory Cough Coughing blood Wheezing Difficulty in breathing

- Bronchitis Pneumonia Chest pain Production of phlegm Other

Gastrointestinal Nausea Vomiting Diarrhea Constipation Gas

- Belching Black stools Blood in stools Indigestion Bad breath Rectal pain
- Hemorrhoids Abdominal pain/cramps Parasites Chronic laxative use
- Gallbladder problems

Neuro-psychological Loss of balance Lack of coordination Concussion

- Depression Anxiety Stress Bad temper Bi-polar

Genito-Urinary Pain on urination Frequent Urination Blood in urine Urgency to urinate

- Kidney stones Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection
- Pain in genitals Itching in genitals Other

Female Frequent vaginal infections Pelvic infection Endometriosis Vaginal discharge

- Fibroids Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods

- Breast tenderness Breast lumps Fertility problems Hot flashes Moodiness related to periods

_____ # pregnancies _____ # births _____ # miscarriages _____ # abortions

_____ # premature births _____ # cesareans _____ # difficult delivery

Menstrual flow: Heavy Light Clots Painful spotting between periods Color of menses _____

Length of period _____ Date of last period _____ Days in cycle _____

First date of last period _____ Age of first period _____ Duration of periods _____ days, cycle _____ days

Do you practice birth control ? Yes No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

PMS symptoms _____

Female (continued)

Is there any possibility that you are pregnant? Yes No

Menopause: Age _____ Hysterectomy/age and reason _____
HRT _____

Male Prostate problems Discharge Impotence Frequent seminal emission
 Fertility problems Ejaculation problems Painful/swollen testicles Other

Other health concerns:

I have completed this form correctly to the best of my knowledge.

Signature: _____ Adult Patient Parent or Guardian Spouse

Print Name: _____ **Date:** _____