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 _____

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 _____

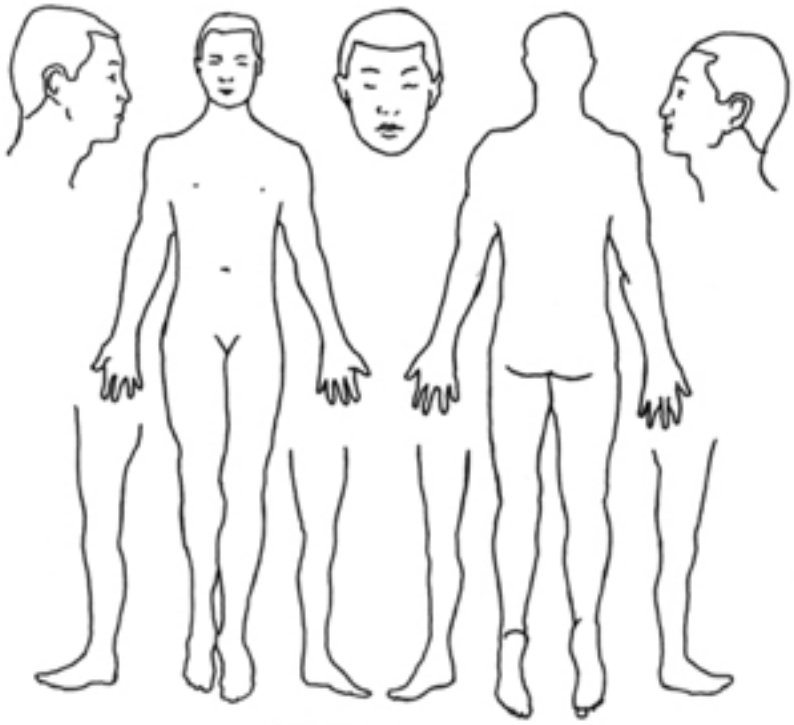
Afternoon _____

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 ❑Dizziness ❑Migraines ❑Concussion

❑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

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Cardiovascular ❑High Blood Pressure ❑Low Blood Pressure ❑Chest pain ❑Palpitations

❑Fainting ❑Phlebitis ❑Irregular heartbeat ❑Rapid heartbeat ❑Varicose veins ❑Other

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Respiratory ❑Cough ❑Coughing blood ❑Wheezing ❑Difficulty in breathing

❑Bronchitis ❑Pneumonia ❑Chest pain ❑Production of phlegm ❑Other

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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

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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:** _____