Name	Date

What would you like to work on today?

_____

_____

What are the main symptoms? How long have they occurred?

_____

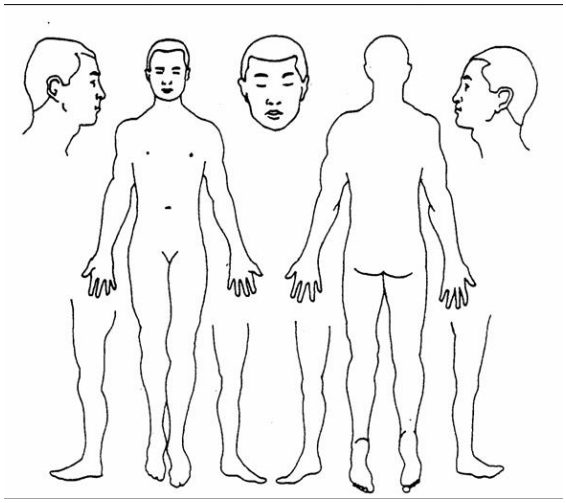
_____

Use the following illustration to indicate painful or distressed areas:

Are you experiencing pain/discomfort in any area of your body? Y / N

If yes, using the models below, please indicate the location of the discomfort by using the symbol that best describes the feeling:

N N N Numbness
X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching



Medical History

Please check all that apply	Date Diagnosed		Date Diagnosed
Diabetes	___ / ___ / ___	Cardiovascular Disease	___ / ___ / ___
Asthma/COPD	___ / ___ / ___	Mental Disorder	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___
			___ / ___ / ___

Family Medical History

(Please note the family relation)	Date Diagnosed		Date Diagnosed
Diabetes	___ / ___ / ___	Cardiovascular Disease	___ / ___ / ___
Asthma/COPD	___ / ___ / ___	Stroke	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
Mental Disorder	___ / ___ / ___	Others	___ / ___ / ___
			___ / ___ / ___

Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (to medications, chemicals or foods):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

For Women:

1. Are you pregnant now? [ ] Yes [ ] No [ ] Unsure
2. Indicate number of occurrences:
   Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____

3. Age: First period _____ Menopause (if applicable) _____

4. Date: Last Pap smear _____ /_____ Last Mammogram _____ / _____

5. Any History of an Abnormal Pap smear? [ ] Yes [ ] No
If so, what / when? _____
6. Is your menstrual cycle regular? [ ] Yes [ ] No
7. Have you been diagnosed with a reproductive organ disorder? [ ] Yes [ ] No
If so, what/for how long? _____

For Men:

1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No
Describe:_____
_____

2.Have you been diagnosed with a reproductive organ disorder? [ ] Yes [ ] No
If so, what/for how long? _____

3. Do you get up at night to urinate? [ ] Yes [ ] No How often?_____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?
_____
5. What treatments have you tried for these problems and how successful have they been?
_____
_____

Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?
(i.e. Vegetarian, Vegan, Low Carb, etc.)_____
_____
2. How many 8 oz glasses of water do you drink daily?_____
3. How many servings of fruits and vegetables daily?_____
4. Any food allergies? If so, what type? _____
5. What types of meat or protein sources do you eat?_____
_____
6. Foods you tend to crave: _____
7. Foods you dislike: _____

Social History

1. How much per day/week do you use of the following?
a) Coffee, tea, soft drinks:
_____
b) Alcohol:
_____
c) Cigarettes, cigars, other tobacco:
_____
d) Other drugs:
_____

2. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No
If so, please list which and when you first noticed symptoms? _____

3. Please describe your current exercise regimen:
Hours per week: _____ Activities: _____
[ ] No exercise

IV. Surgical History

_____Date _____

_____Date _____

_____Date _____

I am providing this information as true and correct to the best of my knowledge,

Patient: _____ Date: _____