CONFIDENTIAL HEALTH HISTORY SS#_____ Date_____

Name_____ Name you like to be called_____

Address _____ Home phone_____

_____ Work phone_____

Email_____ Cell phone_____

Age_____ Date of birth_____ How old do you feel? _____

Marital Status_____ Spouse's name_____

Names and ages of children_____

Employer/Business_____ Occupation_____

Employer Address_____

Contact in case of emergency_____ Phone_____

Who is responsible for your account? ☐Self, ☐Parent, ☐Insurance (type)_____

Who referred you to us?_____ Family Doctor_____

What types of health care have been the most helpful for you in the past?_____

_____

Do you have problems related to an ☐automobile,☐work, or☐other (type) _____accident?

What do you think caused your health problems?_____

Do your problems affect your ☐work, ☐sleep, ☐activities, ☐relationships, ☐ other?_____

When your problems are at their worst, how do you feel?_____

How will you feel in 5 years if you don't get taken care of now?_____

What conditions have you sought treatment for in the past year?_____

_____

List the drugs and supplements you take and any orthopedic supports you wear:_____

_____

List the age, general health or cause of death, and serious illness history of your relatives:

Spouse_____ Mother_____ Father_____

Siblings_____ Children_____

Do any other diseases run in your family? _____

Do you feel radiantly healthy?_____ If not, how long since you have?_____

Are you ready to do whatever it takes to regain your health?_____

CHRONOLOGICAL STRESS AND HEALTH HISTORY FORM

NAME_____ AGE_____ DATE_____

Please list the approximate ages of occurrences:

Surgeries	Age	Serious Diseases/Infections	Age

Injuries/Accidents/Fractures	Age	Head Trauma/Unconsciousness	Age

Dental Procedures	Age	Stressful Events/Situations	Age

Pregnancies/Births/Abortions	Age	Toxic/Chemical Exposures	Age

Please record here anything you didn't have space for above, or stressful events or conditions that do not fit into any of the categories we have listed:

_____

_____

_____

_____

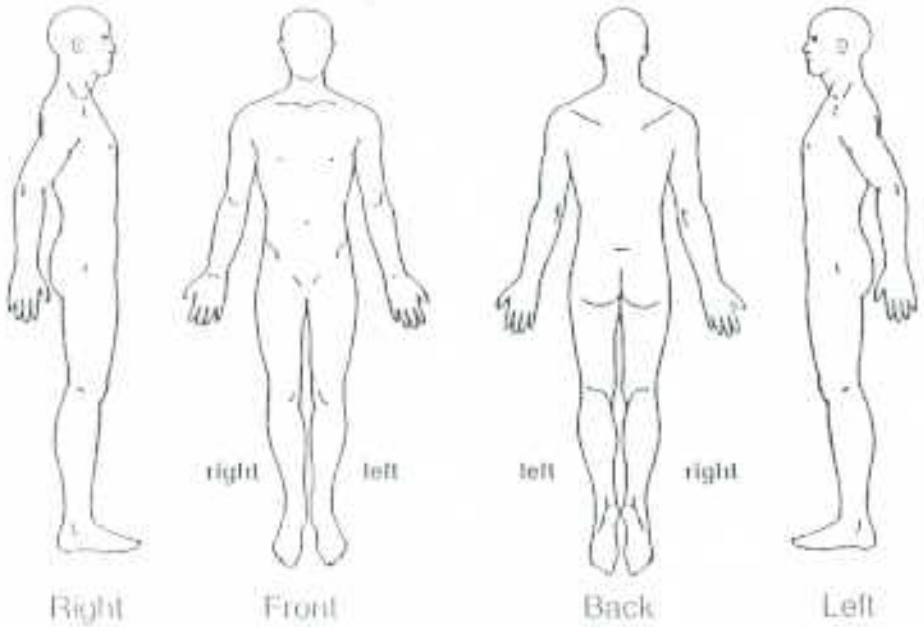
_____

NAME_____ **DATE**_____

Please circle the appropriate number from 0 as the least/never to 4 as the most/always:

Arthritis (Degenerative)	0	1	2	3	4
Arthritis (Rheumatoid)	0	1	2	3	4
Arthritis (Other)	0	1	2	3	4
Multiple bone/joint disease	0	1	2	3	4
Multiple bone/joint pain/swelling/stiffness	0	1	2	3	4
Foot/ankle pain/problems	0	1	2	3	4
Knee pain/problems	0	1	2	3	4
Hip/leg pain/problems	0	1	2	3	4
Limp/problems walking	0	1	2	3	4
Low back pain/stiffness	0	1	2	3	4
Mid-back pain/stiffness	0	1	2	3	4
Neck pain/stiffness	0	1	2	3	4
Pain between shoulders/upper back	0	1	2	3	4
Headaches	0	1	2	3	4
Jaw/TMJ pain/clicking	0	1	2	3	4
Wrist/hand pain/problems	0	1	2	3	4
Elbow/arm pain/problems	0	1	2	3	4
Shoulder Pain/problems	0	1	2	3	4
Muscle tension	0	1	2	3	4
Muscle weakness	0	1	2	3	4
Numbness/tingling	0	1	2	3	4
Spinal curvature	0	1	2	3	4

Please draw in the diagrams below all your significant scars, from injuries and surgeries:



COMPREHENSIVE FUNCTIONAL ASSESSMENT

Name_____ **Date**_____ _____

List your most pressing health issues in order of importance:

_____

_____

_____

_____

_____

_____

List the medications and nutritional supplements you take:

_____

_____

_____

_____

_____

_____

Please circle the appropriate number on all questions- 0 as the least/never to 4 as the most/always

Intestine					
Feeling that bowels do not empty completely	0	1	2	3	4
Lower abdominal pain relief by passing stool or gas	0	1	2	3	4
Alternating constipation and diarrhea	0	1	2	3	4
Diarrhea	0	1	2	3	4
Constipation	0	1	2	3	4
Abnormal, hard, dry, small, or bloody stool	0	1	2	3	4
Coated tongue/"fuzzy" debris on tongue	0	1	2	3	4
Passing large amount of foul smelling gas	0	1	2	3	4
More than 3 bowel movements daily	0	1	2	3	4
Frequent usage of laxatives	0	1	2	3	4
Crohn's Disease/Colitis	0	1	2	3	4
_____ total					
Stomach Enzymes					
Excessive belching, burping or bloating	0	1	2	3	4
Gas immediately following a meal	0	1	2	3	4
Offensive breath	0	1	2	3	4
Difficult bowel movements	0	1	2	3	4
Sense of fullness during and after meals	0	1	2	3	4
Difficulty digesting fruits and vegetables	0	1	2	3	4
Undigested foods found in stools	0	1	2	3	4
_____ total					
Stomach Irritation					
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3	4
Frequent usage of antacids	0	1	2	3	4
Feeling hungry an hour or two after eating	0	1	2	3	4
Heartburn when lying down or bending forward	0	1	2	3	4
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3	4
Digestive problems that subside with rest/relaxation	0	1	2	3	4
Heartburn from spicy food, chocolate, citrus, alcohol, caffeine	0	1	2	3	4
Nervous stomach/ulcers	0	1	2	3	4
_____ total					
Pancreatic Enzymes					
Constipation from roughage or fiber	0	1	2	3	4
Indigestion and fullness for 2-4 hours after eating	0	1	2	3	4
Soreness on left side under rib cage, especially after eating	0	1	2	3	4
Excessive passage of gas	0	1	2	3	4
Nausea/vomiting	0	1	2	3	4
Undigested, foul smelling, mucousy, greasy, or poorly formed stool	0	1	2	3	4
Frequent urination	0	1	2	3	4
Increased thirst and appetite	0	1	2	3	4
Difficulty losing weight	0	1	2	3	4
_____ total					
Biliary					
Distress from greasy or high fat foods	0	1	2	3	4
Lower bowel gas and/or bloat several hours after eating	0	1	2	3	4
Bitter metallic taste in mouth, especially in the morning	0	1	2	3	4
Unexplained itchy skin	0	1	2	3	4
Yellowish cast to eyes	0	1	2	3	4
Stool color alternating from clay-colored to normal brown	0	1	2	3	4
Reddened skin, especially palms	0	1	2	3	4
Dry or flaky skin and/or hair	0	1	2	3	4
History of gallbladder attacks or stones	0	1	2	3	4
Have you had your gallbladder removed?	no(0)			yes(4)	
_____ total					

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Blood Sugar Issues					
Craving sweets during the day	0	1	2	3	4
Irritability if meals are missed	0	1	2	3	4
Dependence on coffee to keep yourself going or started	0	1	2	3	4
Lightheadedness if meals are missed	0	1	2	3	4
Fatigue relieved by eating	0	1	2	3	4
Shakiness, jitters, tremors	0	1	2	3	4
Agitation, easily upset, nervousness	0	1	2	3	4
Poor memory, forgetfulness	0	1	2	3	4
Blurred vision	0	1	2	3	4
_____ total					
Insulin Resistance					
Fatigue after meals	0	1	2	3	4
Craving sweets during the day	0	1	2	3	4
Sugar cravings not relieved by eating sweets	0	1	2	3	4
Need to eat sweets after meals	0	1	2	3	4
Waist girth equal to or larger than hip girth	0	1	2	3	4
Frequent urination	0	1	2	3	4
Increased thirst & appetite	0	1	2	3	4
Difficulty losing weight	0	1	2	3	4
_____ total					
EENT/Respiratory					
Altered sense of smell	0	1	2	3	4
Bleeding/sore gums	0	1	2	3	4
Earaches/infections	0	1	2	3	4
Frequent colds/flu	0	1	2	3	4
Hearing/vision changes	0	1	2	3	4
Persistent hoarseness	0	1	2	3	4
Post-nasal drip	0	1	2	3	4
Ringing/buzzing in ears	0	1	2	3	4
Sinus problems/infections	0	1	2	3	4
Chronic sore throat	0	1	2	3	4
Persistent swollen glands	0	1	2	3	4
Eyes watery/itchy	0	1	2	3	4
Dark circles under eyes	0	1	2	3	4
Ears itchy	0	1	2	3	4
Ears feel clogged	0	1	2	3	4
Nose stuffiness/excessive mucus	0	1	2	3	4
Hayfever/allergies	0	1	2	3	4
Chronic coughing	0	1	2	3	4
Frequent need to clear throat	0	1	2	3	4
Swollen/discolored tongue, gums, lips	0	1	2	3	4
Canker sores	0	1	2	3	4
Chest congestion	0	1	2	3	4
Asthma/bronchitis	0	1	2	3	4
Shortness of breath	0	1	2	3	4
_____ total					
Circulation					
Anemia	0	1	2	3	4
Sores that don't heal	0	1	2	3	4
Bruising too easily	0	1	2	3	4
Chest pain/tension on exertion	0	1	2	3	4
High/low blood pressure	0	1	2	3	4
Leg cramps/restlessness	0	1	2	3	4
Poor circulation	0	1	2	3	4
Swollen ankles	0	1	2	3	4
_____ total					

Urination

Chronic bladder infections	0	1	2	3	4
Kidney problems/stones	0	1	2	3	4
Loss of bladder control	0	1	2	3	4
Frequent or urgent urination	0	1	2	3	4
Urine discolored/odorous	0	1	2	3	4
Painful or burning urination	0	1	2	3	4
_____ total					

General

Loss of appetite	0	1	2	3	4
Alcohol intolerance	0	1	2	3	4
Body odor (excessive)	0	1	2	3	4
Substance abuse issues	0	1	2	3	4
Chemical sensitivity	0	1	2	3	4
Acne/rashes	0	1	2	3	4
Eczema/dermatitis/hives	0	1	2	3	4
Persistent fever	0	1	2	3	4
Headaches/migraines	0	1	2	3	4
Unusual weight change	0	1	2	3	4
Frequent illness	0	1	2	3	4
Binge eating/drinking	0	1	2	3	4
Food cravings	0	1	2	3	4
Food intolerance	0	1	2	3	4
Achiness all over	0	1	2	3	4
Muscle weakness	0	1	2	3	4
Joint pain/arthritis	0	1	2	3	4
"Fluie" sensations	0	1	2	3	4
Unusual soreness or fatigue after exertion	0	1	2	3	4
Excessive sweating	0	1	2	3	4
Dry eyes/mucous membranes	0	1	2	3	4
_____ total					

Cognition

ADHD/attention deficit	0	1	2	3	4
Foggy thinking/muzzy head	0	1	2	3	4
Hyperactivity	0	1	2	3	4
Memory loss	0	1	2	3	4
Mental illness	0	1	2	3	4
Mood swings	0	1	2	3	4
Confusion/poor comprehension	0	1	2	3	4
Poor coordination/balance, increasing clumsiness	0	1	2	3	4
Learning disabilities	0	1	2	3	4
Problems with stress	0	1	2	3	4
_____ total					

Adrenal Fatigue

Problems staying asleep/waking during night	0	1	2	3	4
Craving salt	0	1	2	3	4
Difficulty getting started in the morning	0	1	2	3	4
Afternoon fatigue	0	1	2	3	4
Dizziness when standing up quickly	0	1	2	3	4
Afternoon headaches	0	1	2	3	4
Headaches with exertion or stress	0	1	2	3	4
Weak nails	0	1	2	3	4
Eyes light sensitive	0	1	2	3	4
_____ total					

Cortisol Elevation

Problems sleeping/insomnia	0	1	2	3	4
Tendency to perspire easily	0	1	2	3	4
Feeling of being under high amounts of stress/irritability	0	1	2	3	4
Weight gain when under stress	0	1	2	3	4
Waking up tired even after 6 or more hours of sleep	0	1	2	3	4
Excessive perspiration or perspiration with little or no activity	0	1	2	3	4
Anxiety/nervousness	0	1	2	3	4
_____ total					

Pituitary- High

Increased sex drive	0	1	2	3	4
Tolerance to sugars reduced	0	1	2	3	4
"Splitting" headaches	0	1	2	3	4
_____ total					

Thyroid-High

Heart palpitations	0	1	2	3	4
Inward trembling	0	1	2	3	4
Increased pulse even at rest	0	1	2	3	4
Nervousness and emotional stress	0	1	2	3	4
Insomnia	0	1	2	3	4
Night sweats	0	1	2	3	4
Difficulty gaining weight	0	1	2	3	4
_____ total					

Pituitary-Sluggish

Diminished sex drive	0	1	2	3	4
Menstrual disorders or lack of menstruation	0	1	2	3	4
Increased ability to eat sugars without symptoms	0	1	2	3	4
_____ total					

Thyroid- Sluggish

Fatigue, sluggishness	0	1	2	3	4
Feeling cold on hands, feet, all over	0	1	2	3	4
Needing excessive amounts of sleep to function properly	0	1	2	3	4
Tendency to gain weight even with low-calorie diet	0	1	2	3	4
Gain weight easily	0	1	2	3	4
Difficult, infrequent bowel movements	0	1	2	3	4
Depression, lack of motivation	0	1	2	3	4
Morning headaches that wear off as the day progresses	0	1	2	3	4
Thinning of outer third of eyebrow	0	1	2	3	4
Thinning of hair on scalp, face, or genitals, or excessive falling hair	0	1	2	3	4
Dryness of skin and/or scalp	0	1	2	3	4
Mental sluggishness	0	1	2	3	4
_____ total					

Prostate (Males Only)

Difficulty with dribbling after urination	0	1	2	3	4
Frequent/painful urination	0	1	2	3	4
Pain on inside of legs or heels	0	1	2	3	4
Feeling of incomplete bowel evacuation	0	1	2	3	4
Leg nervousness at night	0	1	2	3	4
_____ total					

Males only

Decrease in libido	0	1	2	3	4
Decrease in spontaneous morning erections	0	1	2	3	4
Decrease in fullness of erections	0	1	2	3	4
Difficulty in maintaining erections	0	1	2	3	4
Spells of mental fatigue	0	1	2	3	4
Inability to concentrate	0	1	2	3	4
Episodes of depression	0	1	2	3	4
Muscle soreness	0	1	2	3	4
Decrease in physical stamina	0	1	2	3	4
Unexplained weight gain	0	1	2	3	4
Increase in fat distribution around chest and hips	0	1	2	3	4
Sweating attacks	0	1	2	3	4
Increase in emotional swings	0	1	2	3	4
_____ total					

Menstruating Females Only

Are you perimenopausal?	no(0)				yes(4)
Alternating menstrual cycle lengths?	no(0)				yes(4)
Extended menstrual cycle, greater than 32 days	no(0)				yes(4)
Shortened menstrual cycle, less than every 24 days	no(0)				yes(4)
Pain and cramping during periods	0	1	2	3	4
Scanty menstrual blood flow	0	1	2	3	4
Heavy/unusual blood flow	0	1	2	3	4
Breast pain and/or swelling during menses	0	1	2	3	4
Pelvic pain and/or swelling during menses	0	1	2	3	4
Irritability/depression during or before menses	0	1	2	3	4
Acne breakouts	0	1	2	3	4
Sexual difficulties	0	1	2	3	4
Facial hair growth	0	1	2	3	4
Hair loss/thinning	0	1	2	3	4
Ovarian cysts	0	1	2	3	4
Vaginal itching/discharge/pain	0	1	2	3	4
_____ total					

Menopausal Females Only

How long since last period?	_____				
Postmenopausal uterine bleeding?	no(0)				yes(4)
Hot flashes	0	1	2	3	4
Mental fogginess	0	1	2	3	4
Disinterest in sex	0	1	2	3	4
Mood swings	0	1	2	3	4
Depression	0	1	2	3	4
Painful intercourse	0	1	2	3	4
Shrinking breasts	0	1	2	3	4
Facial hair growth	0	1	2	3	4
Acne	0	1	2	3	4
Vaginal pain, dryness or itching	0	1	2	3	4
_____ total					

Unlisted/Other

_____	0	1	2	3	4
_____	0	1	2	3	4
_____ total					

TOTAL-PAGE 2 _____

GRAND TOTAL _____