Health and Lifestyle Overview

Name: _____________________________ Today's Date: _________

Please tell me what are the top 5 issues bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach additional sheets if more space is required.)

Is your health currently getting better, worse or staying the same. How do you know?

What have you tried to do to improve your state of health (e.g. other doctors, treatments, etc.)?

Please list the names, phone #'s and specialties of all other health care providers with whom you are currently working and the condition(s) they are treating:

Please list any other health concerns/conditions, even if you think they may not be important.

Why did you choose our office?

For our time together to be successful, what do you want to take place over the course of your care here?

How long do you feel this will take?

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

Please list your special interests and passions:

Please list any self-destructive lifestyle habits (e.g. smoking, lack of exercise, insufficient sleep, addictions, etc.)

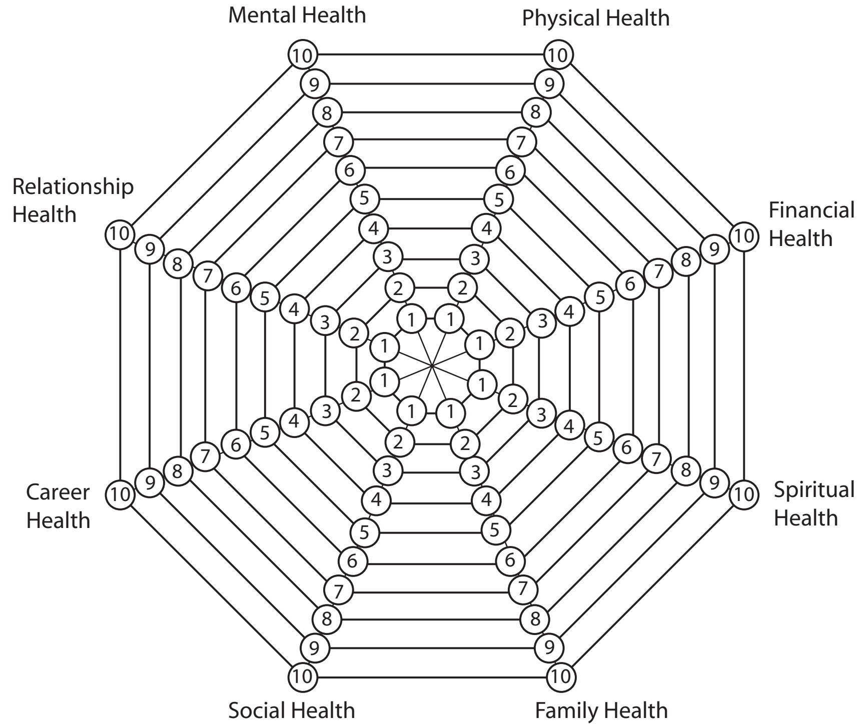
Web of Wellness

Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center choose your level of satisfaction in each of the areas

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not satisfied
10 = Extremely satisfied



What might it <u>cost you</u> if you don't improve your lifestyle and underlying contributors to your compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to <u>change the underlying causes</u> of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed).

What <u>obstacles</u> could prevent you from changing those lifestyle factors that are undermining your health?

What might <u>stop you</u> from following the therapeutic protocols that I may prescribe for you?

Who would be willing to <u>support you</u> in your health goals?

Patient Medical History

Name________________________________ Sex____ Date of Birth _______ Age_____
Height________ Weight_______ Place of Birth _________________________
Religion (optional) ______________________
Marital Status: Single Married Domestic Partner Divorced Widowed Other
Names, Ages & Genders of children:

Occupation: _____________________

Women only (next four lines):

Age at onset of menstruation: _________ Date of most recent menses:__________
Are you peri-menopausal? _________ Age at onset of menopause:__________
# of pregnancies: _________ # of miscarriages: _________
# of abortions: _______________ # of deliveries:_________________

How was your health as a child?: excellent good fair poor

Were there any complications with your birth? Please explain:_________________________________

Are you adopted? _______ Were you breast fed?__________ How long?________________________

Did you have any serious emotional or mental traumas as a child? Please explain:________________

____

Check diseases for which you have been immunized:

☐ Measles ☐ Mumps ☐ Rubella ☐ Small pox ☐ Influenza ☐ Tetanus ☐ Diphtheria ☐ other______

What is your blood type?: **A** **B** **AB** **O** **don't know**

Serious Illnesses / Injuries / Surgeries	Date	Outcome

	Allergies	Type of Reactions
	Animal hair/dander:	
	Chemicals:	
	Drugs, medications:	
	Dust, molds:	
	Food:	
	Grasses, weeds, pollen:	
	Others:	

Tests History
Please list the date of your most recent procedures. Circle any that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
❑ Chest x-ray		❑ TB Test		❑ Pap Smear		❑ PSA	
❑ Kidney x-ray		❑ EKG		❑ Mammogram		❑ HIV/AIDS	
❑ G.I. Series		❑ MRI		❑ Sigmoidoscopy		❑ Others:	
❑ Colon x-ray		❑ CAT Scan		❑ Colonoscopy			
❑ Spinal x-ray		❑ Cholesterol		❑ Rectal Exam			
❑ Blood Tests		❑ Cardiac Stress Test		❑ Hormone Tests		❑ Complete Physical Exam	

Health Habits (Please print clearly)

Please list all medications (prescription & OTC), vitamins & supplements, herbs, and homeopathic remedies you are currently taking, include dosage, who prescribed or recommended them and the condition you take them for (attach a separate sheet if necessary):

Please check any of the following medications you are currently taking or have taken within last 3 months:

Allergy medication	Chemotherapy	Oral Contraceptives	Thyroid medication
Antacids	Cortisone	Pain Medication	Ulcer Medication
Anti-inflammatory	Heart Medications	Psychiatric medications	Other ________________
Antibiotic / Anti-fungal	High Blood Pressure	Radiation therapy	____________________
Antidepressants	Hormones	"Recreational" Drugs	____________________
Antidiabetic/insulin	Laxatives	Relaxants	____________________
Aspirin / Tylenol / Advil	Lithium	Sleeping Pills	

Do you now or have you in the past:
(Circle day / week / month, as appropriate):

❑ Use tobacco (smoke/chew)	_____packs per day / week	For how many years?_____	Age quit__
❑ Smoke marijuana	_____times per day / week	For how many years?_____	Age quit__
❑ Use recreational drugs Types: ____________________	_____times per week / month	For how many years?_____	Age quit__
❑ Drink coffee	_____cups per day / week	For how many years?_____	Age quit__
❑ Drink black/green/chai tea	_____cups per day / week	For how many years?_____	Age quit__
❑ Drink alcohol (type:__________)	_____drinks per day / week	For how many years?_____	Age quit__
❑ Drink sodas	_____drinks per day / week	For how many years?_____	Age quit__
❑ Use artificial sweeteners	_____packets per day / week	For how many years?_____	Age quit__

What are your favorite foods:____

Do you crave sweets?_____ At what time(s)?:___________ Do you salt your food at the table?________

Are there other foods you crave? Bread Pasta Dairy Meat Fried Salty Other:_____________

What foods do you really dislike: ____

Do you snack? ______ When (between meals, bedtime, nighttime, all day, etc.)? __________________
What types (sweets, chips, nuts, fruit, etc.) ____

Do you regularly skip meals? Breakfast Lunch Dinner

Do you make an effort to eat organically grown foods? ______ What % of your diet?_________________

How many times a week do you eat in a restaurant? Breakfast______ Lunch______ Dinner________

What types of restaurants____

Do you drink purified or bottled water? _____ If so, what method/brand do you use?____________________

Are you on a restricted diet due to religious or other beliefs (e.g. Hindu, Kosher, Halal, Vegan, etc.)? If so, please describe:____

Are you on any other specific diet? If so, please specify:____

Would you like to increase or decrease your weight? If so, by how much:________________________

When did you last have a significant (more than 10 pounds) change in weight?____________________

Do you currently or have you in the past had issues with eating disorders (anorexia, bulimia, yo-yo dieting, etc.)? If so, please describe: ____

What exercise do you do and how often?____

How many hours of sleep do you get each night? _______ What time do you usually fall asleep? ______
Do you wake up during the night? What time(s)? _________ Do you wake in the morning rested?_______

Are you presently sexually active? _______ Any difficulties? _______ Method of birth control?__________

Rate your current stress level from 1-10: _________ How much does this affect you (1-10)?__________

What are the major stresses in your life now? ____

Rate your current emotional health: excellent good fair poor unstable crisis

Are you currently in psychotherapy?_________ Do you have a good support network/team? _________

Do you have a regular meditative or contemplative practice? Describe: __________________________

How many hours of relaxation (not including sleep) do you give yourself during the work week?________

During weekends? _______ Favorite recreational activities?___________________________________

Describe your current living situation (apartment/house/other, rent/own, housemates, family members, etc):

Do you have pets? What types? ____________________

Does your home environment have a supportive effect on your health? ______ Describe any factors in your home environment that may be affecting your health (noise, mold/dampness, construction, conflicts, etc.)
____

Do you have an air purifier in the room you sleep in?______ What type/brand?________________________

Have you traveled or lived in a developing country (where, when)? ___________________________________

When was your last eye exam?___________ Do you wear glasses/contacts?_______

When was your last dental exam/cleaning? _____________
Do you have amalgam (silver) fillings?______ Any other dental problems?________________________

Have you been exposed to toxic chemicals? _____ If yes, which ones? ________________________

Are you considering any elective surgery or medical procedures in the near future?_____________________

Have you received acupuncture or Oriental Medicine Therapy in the past? With whom? For what condition? How did it work for you? ____

Do you have any questions or concerns about receiving acupuncture or other medical care (please describe)?
____

Personal Health History: Check the box if you have experienced any of the following. Circle any that are still present:

❑ Adverse reaction to medical treatment	❑ Immune Disorder / Auto-immune Disease
❑ Alcoholism / Chemical Dependency	❑ Kidney Disorder
❑ Allergies	❑ Low Blood Pressure
❑ Anemia	❑ Musculo-skeletal Disorder
❑ Arthritis or rheumatism	❑ Organ Transplant
❑ Artificial heart, valve or joints	❑ Pacemaker
❑ Bleeding Disorder	❑ Respiratory Disorder
❑ Cancer or Tumor	❑ Rheumatic Fever
❑ Diabetes	❑ Sciatica/Back pain
❑ Eating Disorder	❑ Seizures/Epilepsy
❑ Eye Disorder	❑ Skin Disorders
❑ Gout	❑ Stomach or Intestinal Disorder
❑ Headaches	❑ Stroke
❑ Heart Disease	❑ Thyroid Disease
❑ Hemophilia	❑ Transfusion (before March 1985)
❑ Hepatitis, jaundice or Liver disorder	❑ Tuberculosis
❑ Herpes (oral, genital)	❑ Ulcer
❑ HIV / AIDS	❑ Urinary Tract Disorder
❑ High Blood pressure	❑ Sexually Transmitted Disease
❑ High cholesterol	❑ Other:

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check (x) if your blood relatives have/had: Disease		Relationship
Father						Arthritis, gout	
Mother						Asthma, Allergies	
Brothers						Cancer	
						Alcoholism/Chemical dependency	
						Diabetes	
						Heart disease, stroke	
Sisters						High blood pressure	
						Autoimmune disease	
						Tuberculosis	
						Mental Illness/Suicide	
						Other	

Diet Survey

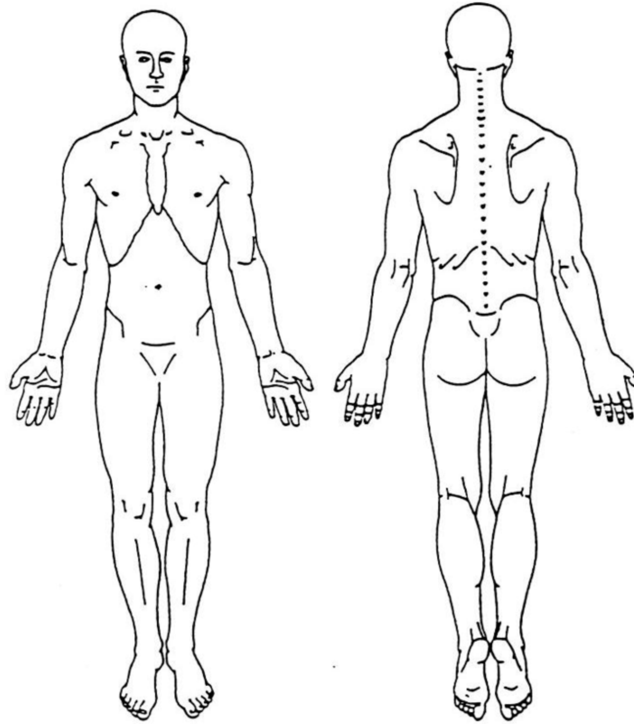
Please list everything you have eaten and drank in the past 3 days:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Body Diagram

Instructions:

On the body diagram below, please indicate where your pain is located at the present time.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

No Pain Worst Pain Possible

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3

Category VI (continued)				
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	

Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XI	0	1	2	3
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

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

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" -type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal		Yes	No	
Alternating menstrual cycle lengths		Yes	No	
Extended menstrual cycle (greater than 32 days)		Yes	No	
Shortened menstrual cycle (less than 24 days)		Yes	No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?		______years		
Since menopause, do you ever have uterine bleeding?		Yes	No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3