ORIEN AL MEDICINE INTAKE FOR

Name:____________________ Date:____________

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. ____________________ Approx. Date of Onset:____________
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other____________

2. ____________________ Approx. Date of Onset:____________
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other____________

3. ____________________ Approx. Date of Onset:____________
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Other therapies tried: ☐Medications ☐Surgery ☐Chiropractic ☐Phys. Therapy ☐Other____________

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1.____________ 4.____________
2.____________ 5.____________
3.____________ 6.____________

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1.____________ 4.____________
2.____________ 5.____________
3.____________ 6.____________

Please list **allergies** that you have to any of the following:

Drugs:____________ Foods:____________

Other (i.e. pollen, paint, etc.):____________

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

____

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____

Personal Habits:

☐Tobacco packs/day________
☐Alcohol drinks/wk________
☐Coffee/tea/cola cups/day________
☐Recreational drugs times/wk________

☐High Stress Level Reason________

Do you follow any diet regimens/restrictions?
☐Yes ☐No
If Yes, describe:____________

Work Activity:

☐Sitting % of time________
☐Standing % of time________
☐Light labor % of time________
☐Heavy labor % of time________

Exercise:

Do you exercise regularly? ☐Yes ☐No
If Yes, describe & tell how often:____________

____

____

FAMILY INFORMATION

Do you have children? ☐Yes ☐No If Yes, how many?________Ages____________

Are you, or could you be currently pregnant? ☐Yes ☐No Due date____________

Please check if you have had (in the **last three months**)

GENERAL

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Changes in appetite
- ☐ Weight loss/gain
- ☐ Cravings
- ☐ Peculiar tastes
- ☐ Strong thirst
- ☐ Fevers/Chills
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed / bruise easily
- ☐ Sudden energy drop (time?)
- ☐ Fatigue
- ☐ Tremors
- ☐ Poor sleeping
- ☐ Heavy sleeping
- ☐ Dream disturbed sleep
- ☐ Night sweats
- ☐ Dizziness

SKIN AND HAIR

- ☐ Rashes/Hives
- ☐ Itching
- ☐ Dry skin
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Eczema/Psoriasis
- ☐ Loss of hair
- ☐ Pimples/Acne
- ☐ Fungal infections
- ☐ Recent moles
- ☐ Change in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Concussions
- ☐ Glasses/Contacts
- ☐ Eye strain/pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Excessive tearing
- ☐ Poor/blurry vision
- ☐ Night blindness
- ☐ Cataracts/Glaucoma
- ☐ Spots in front of eyes
- ☐ Earaches/Infections
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Sinus problems
- ☐ Post nasal drip
- ☐ Excessive phlegm – color____________
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Swollen glands
- ☐ Sores on lips/tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Teeth problems
- ☐ Gum problems
- ☐ TMJ disorder
- ☐ Grinding teeth
- ☐ **Headaches** (location, triggers, severity)?

Other head & neck concerns:

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Phlebitis

Other heart or blood vessel concerns:

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with deep breath
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Production of phlegm - color?________ Is it ☐thick or ☐thin

Other lung related concerns:

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/Bloating
- ☐ Hiccups
- ☐ Belching
- ☐ Bad breath
- ☐ Blood in stools
- ☐ Black stools
- ☐ Mucus in stools
- ☐ Acid Regurgitation
- ☐ Abdominal pain
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Bedwetting
- ☐ Kidney stones
- ☐ Impotency
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Premature ejaculation
- ☐ Nocturnal emissions
- ☐ Sores on genitals
- ☐ Frequent urinary tract infections
- ☐ Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Hand/wrist pains
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Cramps/spasms
- ☐ General joint pain/stiffness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Joint with limited range of motion____________

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Tics
- ☐ Lack of coordination
- ☐ Memory loss
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily susceptible to stress
- ☐ History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses______ If no longer menstruating, approximate date ceased____________

First day of last menses_______ Length between menses:_______days Duration of period:______days

- ☐ Unusual flow (☐heavy or ☐light)
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Clots in flow
- ☐ Vaginal discharge – color____________
- ☐ Vaginal odor
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Hot flashes
- ☐ Breast lumps/soreness

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP:________________ Results were: normal abnormal unsure

If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation? (i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies______ Births_____ Miscarriages______ Abortions____

Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

Family History: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			