Patient Name: _____ Date:_____

This form will become part of your medical record and the contents are confidential. It is very important to answer all questions, as this will be most helpful in evaluating your condition. Please answer the questions by checking the appropriate space (Yes or No where appropriate)

Occupation: _____ Hobbies:_____

List Work and History Dates: _____ _____

List all provinces, states, and countries in which you have lived: _____
_____ _____
_____ _____

Reason/Goal for your visit and treatment: _____
_____
_____

How did you hear about our clinic? _____

General Health Information: Height: ___ Weight:___ BP(when last taken): ___
When and where did you get your last physical check-up? _____
_____

Chief Complaint and Present Illness
Major area of concern (single worst): _____
_____

List other areas of concern in order of severity:
1._____ 2. _____
3._____ 4. _____
5._____ 6. _____
7._____ 8. _____

Date or age main symptom first began? _____
Began in what state or country? _____
Please complete if relevant. If not applicable, go to section 2.

When and where did latest episode begin and end? _____
How often do episodes occur? O Daily O Weekly or ___ Times/month
How long do they last? O Minute O Hours ___ Days or ___Weeks

What symptoms, if any remain in between attacks? (list in order of severity)
1._____
2._____
3._____

Never free of symptoms? O Yes O No
Free of symptoms? O Yes O No
When?_____

Symptoms worse what time of the day?
O Awakening O Afternoon O Evening O Night O No pattern

Symptoms relieved by medication? Which medication?
_____
O Slightly O Moderately O Completely O Not at all

Symptoms associated with fever or signs of infections? O Frequently O Never
Symptoms are worse after lights have been on an hour? O Yes O No

Early Spring? O Yes O No In June? O Yes O No
In September O Yes O No

MEDICAL HISTORY:
Name any conditions such as kidney trouble, diabetes, heart disease, stroke, loss of consciousness etc., which you presently have or have had: _____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had a birth defect? O Yes O No
If yes, explain_____
Have you had a birth injury? O Yes O No
If yes, explain_____

Immunization: Have you ever had:
Please include ***reactions*** if any:

Smallpox vaccination?	O Yes	O No	If yes, when? _____
DPT or tetanus toxoid?	O Yes	O No	If yes, when? _____
Polio immunization?	O Yes	O No	If yes, when? _____
Measles/Mumps/Rubella?	O Yes	O No	If yes, when? _____
Flu vaccine?	O Yes	O No	If yes, when? _____
HPV vaccine?	O Yes	O No	If yes, when? _____
Hep A/B vaccine?	O Yes	O No	If yes, when? _____
Pneumococcal vaccine?	O Yes	O No	If yes, when? _____

Other: _____

List medications you are presently taking including dosage:
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List supplements and remedies (non-pharmaceuticals i.e. Herbs, homeopathics, vitamins/minerals) you are presently taking (include brand):

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

List medications and supplements you have taken in the past:

_____ _____
_____ _____
_____ _____

Hospitalization:

Please list all hospitalizations and state purpose: _____
_____
_____

Please list all operations and give dates: _____
_____
_____
_____

COMMUNICABLE DISEASE: Check items which apply:

Do you now or have you ever had?

Measles	O Yes O No	Rheumatic fever	O Yes O No
German measles	O Yes O No	Polio or meningitis	O Yes O No
Mumps	O Yes O No	Tuberculosis	O Yes O No
Chicken pox	O Yes O No	Valley fever	O Yes O No
Whooping cough	O Yes O No	Infectious mononucleosis	O Yes O No
Diptheria	O Yes O No	Syphilis	O Yes O No
Influenza	O Yes O No	Gonorrhea	O Yes O No
Scarlet fever	O Yes O No	Other: _____	

Studies: Check items, which apply:

In the past 10 years have you had any of the following studies?

	Yes	No	If yes, when?
X-rays of the sinuses			
X-rays of the chest			
X-rays of the stomach, gallbladder or colon			
X-rays of the teeth (dental examination)			
Scans of the whole body, bone, or brain			
Electrocardiogram			
Hearing tests			
Blood or urine tests			
Tuberculin skin test (TB skin test)			
Prostate examination			
Mammography			

SENSITIVITY ANALYSES

Contact Dermatitis: Check items, which apply:
Has your skin ever been bothered by contact with any substances? O Yes O No
If yes, please specify: _____
How widespread was the involvement? _____
How frequently has it recurred? _____
What treatment have you used? _____
Have you ever had?
O Poison oak O Poison Ivy O Poison sumac O
Other_____
Does wearing metal watches, rings, necklaces cause you to "break out"? _____

Insect Sensitivity:
List any insect bite or sting you get that causes greater than normal reaction:_____

Check any reactions you get:

O Hives	O Fainting	O Nausea
O Dizziness	O Shock	O Loss of consciousness
O Vomiting	O Mental confusion	O Large local swelling
O Difficulty breathing	O Difficulty swallowing	O

Other:_____
O Required hospitalization O Anaphylaxis

Do insects seem to single you out? O Yes O No Which insects?_____
How many reactions to insects have you had? _____
What type of treatment do you receive after each reaction? _____

TREATMENT

Allergy: Check items which apply
Have you ever had allergy tests? O Yes O No
If yes, when and what type? _____
_____
With which physician? _____
Are you taking allergy injections at the present time? O Yes O No
If yes, please explain. _____

Do you frequently require emergency treatment for allergy? O Yes O No
How many times per year? _____
List current allergy treatment, if any: _____

FAMILY HISTORY: Check any of the following illnesses, which occurred in your family (blood relative):

	Yes	No	If yes, who?
Migraine			
Hayfever, sinus trouble, or frequent colds			
Asthma, bronchitis or frequent colds			
Hives			
Eczema			
Skin rash from cosmetics, metals, or detergents			
Poison ivy or oak, ultraspore, sumac			
Insect allergy			
Food allergy			
Allergy towards drugs, pills, injections, or immunizations			
Headache			
Vertigo			
Epilepsy			
High blood pressure			
Low blood pressure			
Heart attack			
Heart disease			
Stroke			
Vascular disease			
Blood disease like leukemia, severe anemia, bleeding tendency			
Brain tumours			
Tuberculosis			
Emphysema			
Kidney disease			
Constipation			
Indigestion			
Diarrhea			
Diabetes			
Arthritis			
Undue fatigue			
Cancer			
Psychiatric care			
Depression			
Nervousness			
Nervous breakdown			
Emotional problems			
Drug use			
Other			

Explain: _____

_____

	Present Age	Major illness if any	Age at Death	Cause
Father				
Mother				
Brother				
Sister				
Son(s)				
Daughter(s)				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				

Review of Symptoms

SKIN, HAIR, NAILS: Check past or current skin symptoms

- O Eczema
- O Redness
- O Rash
- O Dryness
- O Oiliness
- O Lumps
- O Petechia
- O Dry hair
- O Scaly lesions
- O Itching
- O Edema (swelling)
- O Cracking
- O Acne
- O Boils
- O Bruise easily
- O Falling/thinning hair
- O Weeping lesions
- O Hives
- O Blanching
- O Peeling
- O Shingles
- O Foot odours
- O Fungus of nails

List the main skin areas involved: _____

Is your skin sensitive to: O Sun O Fabrics O Detergents O Other:_____

Did you have unusually severe acne? O Yes O No

Antibiotics given: O Yes O No How long: _____Type:_____

HEADACHE: Check the items which apply to pain and intensity:

- O Constant
- O Vice-like
- O Pulsating
- O Dull
- O Heaviness
- O Pressure
- O Throbbing
- O Excruciating
- O Tight
- O Burning
- O Soreness
- O Cramp-like
- O Constriction
- O Episodic
- O Drawing
- O Band-like
- O Cutting
- O Acute

Check the location(s) of head pain and associated symptoms:

- O On the right side of head
- O On the back of neck
- O Back of eyes
- O In upper teeth
- O Top of head
- O Back of head
- O Forehead
- O Temple
- O On the left side of head
- O On the crown of head
- O In the cheek
- O Begins slowly
- O Lasts hours
- O Returns regularly
- O Clears without treatment
- O Clears with treatment
- O Lasts seconds
- O Lasts minutes
- O Lasts days
- O Begins suddenly
- O Episodic
- O Relieved by walking

Review of Systems Cont.

Check items associated with headache:

- O Loss of sight
- O Dazzling lights
- O Diarrhea
- O Swelling of eye
- O Inflamed eye
- O Tearing of eye
- O Vertigo
- O Running nose
- O Nasal blockage
- O Visual disturbance
- O Pallor
- O Queasy stomach
- O Abdominal pain
- O Nausea
- O Vomiting
- O Neck/shoulder pain
- O Flushing
- O Chilly sensation
- O Dizziness

Check what your headache is preceded or worsened by:

- O Exercise
- O Odors
- O Alcoholic drinks
- O Arguments
- O Foods
- O Coffee/tea
- O Muscle strain
- O Unusual stimulation
- O Fear
- O Anger
- O Fasting
- O Disappointment
- O Intense light
- O Eye strain
- O Chilling
- O Intense thinking
- O Humidity
- O Overheating
- O Anxiety
- O Rejection
- O Infections
- O Motion
- O Noise
- O Other:_____

EYES: Check symptoms, which apply:

- O Itching
- O Dryness
- O Styes
- O Puffiness
- O Bloodshot
- O Dark circles
- O Cataracts
- O Wear contacts
- O Irritated
- O Burning
- O Crusty lids
- O Twitching lids
- O ”floaters”
- O Blurred vision
- O Glaucoma
- O Near-sighted
- O Watering
- O Pain
- O Granulated lids
- O Swelling of lids
- O Mucus in eyes
- O Sensitive to light
- O Wear glasses
- O Far-sighted

EARS: Check symptoms, which apply:

- O Hearing loss
- O Itching inside
- O Floating sensation
- O Pressure
- O Serous otitis
- O Tubes in ears
- O Nerve deafness
- O Crusting inside
- O Dizziness
- O Pain
- O Frequent infections
- O Plugged ears
- O Wear hearing aid
- O Ringing/roaring
- O Sense of imbalance
- O Fluid accumulation
- O Drainage

Are these symptoms present all year round? O Yes O No

Which is your worst season? O Spring O Summer O Fall O Winter

Which months? _____

NOSE/SINUS: Check each symptom, which applies (to greater than normal degrees):

- O Itches
- O Sneezes
- O Burns
- O Post nasal drip
- O No sense of smell
- O Other _____
- O Blocks
- O Bleeds
- O Blisters
- O Mucus yellow
- O Polyps
- O Runs
- O Crusts
- O Sinus infections
- O Mucus blood-streaked
- O Require nose drops/spray

Review of Systems Cont.

Are these symptoms present all year round? O Yes O No
Which is your worst season? O Spring O Summer O Fall O Winter
Which months? _____
When? O Upon rising O After meals O After medicines
O Upon lying down O At night O Cold
O Hot O Dry O
Other:_____

MOUTH AND THROAT: Check symptoms that apply:

O Cracked lips/corners	O Chapped lips	O Fever blisters
O Sleep with mouth open	O Hoarseness	O Tongue swollen
O Sore/raw tongue	O Lose voice	O Sore throats
O Throat/palate itch	O Difficulty swallowing	O Teeth pain
O Throat clearing	O Throat closes	O Fillings, which type?_____
O Neck glands swell	O Post nasal drip	O Bad taste
O Wear dentures	O Grind teeth in sleep	O Bad breath
O Gum problems	O Cankers	

If you use any of the following, indicate the brand name:

_____Toothpaste	_____Adhesive for dental plates	_____Lipstick
_____Tobacco	_____Mouthwash	_____Chewing gum
_____Chapstick	_____Cough drops	_____Teeth Whitener

Do you have any root canals? O Yes O No Which teeth?_____
Do you have amalgam fillings? O Yes O No

HEART: Check any of these symptoms that you have now or have had in the past:

O Racing heart rate	O Skipped beats	O Murmurs
O Enlargement	O Chest pains	O Angina
O Ankle swelling	O Tingling	O Flushing
O High blood pressure	O Blue lips	O Rheumatic fever

Circulation

O Deep leg pain	O Cold hands/feet	O Varicose veins
O Ulcers	O Leg cramps	O Numbness

Which is your main symptom?_____
When is this symptom worse?

O Morning	O Spring	O Year round
O Mid to late morning	O Summer	O Other:_____
O Mid to late afternoon	O Fall	
O Night	O Winter	

Which medications relieve you best? _____
How soon do these medications relieve you?_____
For how long do these medications relieve you? _____

Do you smoke? O Yes O No
How many per day?___ How long have you smoked?_____
Review of Systems Cont.

Have you ever smoked? O Yes O No How long did you smoke?_____
When did you quit? _____

RESPIRATORY: Check any symptom you have now or have had in the past?

O Wheezing	O Asthma	O Bronchitis
O Frequent colds	O Frequent infections	O Pneumonia
O Frequent coughs	O Pleurisy	O Night sweats
O Croup	O Tight chest	O Heavy chest
O Cough - mucus	O Emphysema	O Short of breath
O Cough – dry		

How far can you walk vigorously before becoming short of breath? _____
Which is your main symptom?_____
When is this symptom worse?

O Morning	O Spring	O Year round
O Mid to late morning	O Summer	O Other:_____
O Mid to late afternoon	O Fall	
O Night	O Winter	

GASTROINTESTINAL: Check symptoms, which apply:

O Heartburn	O Indigestion	O Re-taste food
O Bloating	O Flatulence	O Belch frequently
O Good appetite	O Queasy stomach	O Bloody stools
O Poor appetite	O Frequent nausea	O Stomach aches
O Picky eater	O Frequent vomiting	O Constipated
O Cramping	O Vomit blood	O Anal itching
O Use laxatives	O Diarrhea	O Tarry stools
O Ulcer	O Anal pain	O Rectal bleeding
O Mucus in stools	O Gallbladder trouble	O Hemorrhoids

How often do you have bowel movements?_____

GENITOURINARY: Check items, which apply:

O Kidney disease	O Kidney stones	O Difficult urination
O Prostate trouble	O Painful urination	O Sores
O Bladder disease	O Incontinent	O Have discharge
O Itching	O Burning	O Bedwetting
O Increased urinary frequency	O Hesitancy	O Blood in urine

MUSCULOSKELETAL: Check which items apply:

Do you have: muscle pain?	O Yes O No	How severe (scale 1-10; 10=severe)___
Joint swelling/pain?	O Yes O No	How severe (scale 1-10; 10=severe)___
Has fluid been removed?	O Yes O No	When?_____
Have you ever had any broken bones?	O Yes O No	Which bone(s)?_____

Review of Systems Cont.

Check if you have the symptoms below. Please indicate **R** for right side or **L** for left side.

___Morning stiffness
___Pain in elbows
___Pain in shoulder
___Tingling in hands and fingers
___Numbness in fingers
___Loss of strength in hand
___Always dropping objects
___Left side turning cold
___Right side turning cold
___Fingers and hands turn cold
___Cold feet
___Colour change
___Blue ___Red ___Blanching
___Other:_____
___Cramping in legs when walking
___Cramping in legs when resting
___Limitation of movement in legs
___Limitation in moving arm

NEUROLOGICAL: Check items, which apply:

- O Weakness in limb
- O Numbness
- O Tingling
- O Abnormal walking pattern
- O Tremor
- O Convulsions
- O Blurred vision
- O Double vision
- O Foot drop
- O Spinal pain
- O Neck pain
- O Back pain
- O Abnormal EEG
- O Diagnosis of MS
- O Lack of coordination
- O Tics
- O Seizure

HORMONES: Check items which apply:

Do you have or have you ever had:

Weight loss of more than five pounds during the last 12 months O Yes O No

Weight gain of more than five pounds during the last 12 months O Yes O No

- O Lack of appetite
- O Abnormal thirst
- O Enlarged thyroid
- O Hypoglycemia
- O Notable increase in appetite
- O Diabetes or sugar in the urine
- O Overactive thyroid
- O Weight gain/swelling Of any part
- O Underactive thyroid
- O Cramps in legs

MEN ONLY: Check which items apply:

- O Prostate problems
- O Impotency
- O Urinary dribbling
- O Split-stream urine
- O Hernias
- O Discharge/sores
- O Loss of sexual desire
- O Difficulty attaining an erection
- O Difficulty maintaining an erection
- O Mood changes
- O Venereal disease
- O

Other:_____

WOMEN ONLY: Check which items apply:

- O Breast soreness before periods
- O Breast soreness during periods
- O Had breast biopsy
- O Breast implants
- O Vaginal itching
- O Venereal disease
- O Breast cysts or lumps
- O Breast soreness
- O Had mastectomy
- O Vaginal discharge
- O Pain during intercourse
- O Other:_____

Age of onset of menses? _____

Last menstrual period date? _____

Review of Systems Cont.

O Regular periods	O Had D & C	O Use contraceptive pill
O Irregular periods	O Had miscarriage	O Use foam
O Scant flow	O Use lubricants	O Use douches
O Heavy flow	O Use diaphragm	O Pregnant now
O Partial/total hysterectomy		

Do you have symptoms before periods? _____
How long do they last?_____

Do you have symptoms during periods? _____
How long do they last?_____

Do you have symptoms at ovulation? _____
How long do they last?_____

Last PAP smear? _____

Breasts

Do you do self-breast examinations?	O Yes	O No	
Any lumps?	O Yes	O No	
Pain or tenderness?	O Yes	O No	
Nipple discharge?	O Yes	O No	
Age at menopause? ___	Are you taking hormones? Which one(s)?_____		
Surgery of uterus, ovaries etc.?	O Yes	O No	___Year
D & C?	O Yes	O No	___Year
Cesareans?	O Yes	O No	___Year
Breast surgery?	O Yes	O No	___Year
Mastectomy?	O Yes	O No	___Year
Breast implants?	O Yes	O No	___Year

How many pregnancies? _____ How many live births? _____
How many premature births? _____ How many stillbirths? _____
How many miscarriages? _____
Any complications with pregnancies? O Yes O No
If yes, please specify and state when?_____
_____
Any adopted children? O Yes O No

PSYCHOLOGICAL: Check items, which apply:

O Feel groggy	O Fainting spells	O Often break out in cold sweats
O Short attention span	O Blackouts	O Profuse Sweating
O Unable to reason	O Worried by little things	O Cry often
O Unable to concentrate	O Sweats with anxiety	O Feel insecure
O Forgetful	O Frustration	O Pale
O Startled by sudden noises	O Psychiatric care	O Restless legs
O Shaky	O Amnesia	O Considered clumsy
O Considered a nervous person	O Had shock therapy	O Unable to coordinate muscles
O Frequently keyed up/jittery	O Go to pieces easily	O Have difficulty falling asleep

Review of Systems Cont.

O State of anxiety	O Numbness	O Have difficulty staying asleep
O Unusual tension	O Listless	O Have difficulty staying awake
O Often feel suddenly scared	O Withdrawn feeling	O Sleep walking
O Feel "lost" in time	O Had a nervous breakdown	O Hyperactive
O Often awakened by frightening dreams		O Use tranquilizers
O Family member had nervous breakdown		O Am a workaholic
O Hospitalized for nerves	O Misunderstood by others	O Often unable to work
O Aggressive	O Often unhappy	O Extremely shy or sensitive
O Have had hallucinations	O Irritable	O Have had visions
O Easily flare in anger	O Feeling of hostility	O Have heard voices
O Am being controlled by other forces		O Have overused alcohol
O Have overused drugs	O been addicted to a drug	O Has seriously considered suicide

O Other: _____

Exactly what do you do in your occupation or daily life? _____
_____

LIFESTYLE HISTORY:

I drink daily: coffee ____ decaff coffee ____ alcohol ____ soft drinks ____
Water ____ Herbal tea ____ milk____ juice ____

Amount of tobacco consumed? ____ per day

Do you use any recreational drugs? O Yes O No
If yes, which type(s) and how often? _____

Do you exercise regularly? O Yes O No
Type and duration: _____

Do you use a relaxation technique? O Yes O No
Type and how often? _____

Sleep

How many hours of sleep do you get? _____
Do you wake up rested? O Yes O No
Do you wake in the middle of the night? O Yes O No What time?_____
Do you recall dreaming? O Yes O No
Do you have recurrent dreams? O Yes O No

Thank you for taking the time to fully fill out this questionnaire. We understand this is a significant effort, but the information collected is essential for the accurate determination of health risk, disease causes and appropriate treatment.

Diet Diary

NAME: _____ DATE: _____

On this sheet of paper please keep a record of the foods and beverages that you eat and drink, approximate amounts, and the time that you consumed them. Include what you eat and drink between meals. Please do not attempt to modify your eating habits just yet – we need to know what your diet consists of now before changes are made. In addition, list any symptoms you experience throughout the day (e.g. drowsiness, headache, bloating, depressed, etc.) and the time of day they occur.

Day 1			Day 2		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms

Day 3			Day 4		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms

Day 5			Day 6		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms

Day 7			Day 8		
Time	Food/Beverage	Symptoms	Time	Food/Beverage	Symptoms