

 Sourland Wellness, Mary M. Parr, L.Ac

323.513.3431

sourlandwellness@gmail.com

Confidential New Patient Information­

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Would you like to be on our email list?\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Place:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ht: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship/Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of the last physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of next physical exam: \_\_\_\_\_\_\_\_\_\_\_\_

Who can we thank for your referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if any of the following apply to you:

* Cardiac Pacemaker
* Seizure Disorder
* Bleeding Disorder
* Fainting Disorder
* Pregnant or trying to become pregnant
* HIV+
* Hepatitis B
* Hepatitis C
* Tuberculosis
* Other

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

NOTE: This is a confidential record of your medical history and will be kept in this office.

Information contained herein will not be released pursuant to HIPAA regulations.

What brings you into our office today (primary complaint)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe how this problem began, or any triggering factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this problem interfere with your daily activities (work, sleep, sex, enjoyment)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anything relieve the problem? If so please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anything make the problem worse? If so please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How has your condition progressed recently? □ Same □ Improving □ Getting Worse

Is your condition: □ Constant □ Frequent □ Intermittent □ Occasional

Pain Level: □ Low □ Slight □ Moderate □ Severe

Describe the Pain: □ Sharp □Dull □Numbness □Tingling □Aching □Burning

 □Stabbing □Throbbing □Other:

Secondary complaints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other concurrent therapies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How are you responding to your present course of treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries/Hospitalizations (please list dates):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Trauma/Accidents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have?** □ Pacemaker □ Metal Implants □ Are you Pregnant? Y/N

Allergies to Food or Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications & Dosages (prescription, OTC, vitamins, supplements, herbs):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stress: □ None □ Low □ Moderate □ Severe Explain Causes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise (type/frequency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Habits: □ Cigarettes □ Coffee □ Tea □ Soda □ Alcohol Drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you? □ skip meals □ snack □ eat large meals □ eat when rushed □ work and eat □ eat but not hungry

Average Daily Diet:

Morning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Afternoon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR MEDICAL HISTORY

□ Cancer □ HIV+ □ Diabetes □ Heart Disease □ High Blood Pressure □ Low Blood Pressure □ Stroke □ Epilepsy

□ Asthma □ Kidney Disease □ Anemia □ Bleeding Disorder □ STD □ Hepatitis □ Jaundice □ Thyroid Disease

□ Chronic Fatigue □ Sudden Weight Loss □ Sudden Weight Gain

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MEDICAL HISTORY

□ Cancer □ Diabetes □ Kidney Disease □ Heart Disease □ High Blood Pressure □ Stroke □ Epilepsy

□ Low Blood Pressure □ Asthma □ Anemia □ Bleeding Disorder □ Hepatitis □ HIV+ □ Thyroid Disease

Respective Family Members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following Sections on Organ Systems evaluation,

please check any problems that are frequent, or that have occurred within the past 3 months.

Other area \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Bones sore/painful □ Loss of Grip □ Swollen Joints □ Weakness

□ Leg cramps at night □ Tingling in feet □ Loss of feeling in hands/feet □ Muscle spasm/cramps

□ Stiffness all over □ Osteoarthritis □ Rheumatoid Arthritis □ Tendonitis □ Sciatica

Onset of Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Better with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe the pain (burning/constant/intermittent/pins&needles/numbness/coldness/sharp/dull) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEAD, EYES, EARS, NOSE AND THROAT

□ Dizziness □ Concussion □ Poor Memory □ Loss of Balance □ Head feels ‘Heavy‘ □ Migraines

□ Headaches (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Eye Strain □ Eye Pain □ Floaters □ Blurred Vision □ Dry Eyes □ Watery Eyes □ Itchy Eyes

□ Ear Ache □ Ear Infections □ Hearing Loss □ Ringing/Buzzing in Ears □ Grinding Teeth □ TMJ □ Teeth Problems

□ Facial Pain □ Facial Paralysis □ Sensation of ‘Lump’ in Throat □ Sinus Problems □ Mucus □ Nose Bleeds

□ Runny Nose □ Congestion □ Frequent Colds □ Sore Throat □ Copious Saliva □ Dry Mouth

□ Difficulty Swallowing □ Hoarseness/Loss of Voice

LUNG SYSTEM

□ Shortness of Breath □ Difficulty Breathing □ Wheezing □ Cough □ Asthma □ Bronchitis

□ Pneumonia □ Difficulty Breathing When Lying Down □ Coughing Blood □ Coughing Phlegm

Sputum color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thick or Thin? \_\_\_\_\_\_\_\_\_\_\_\_\_ Other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEART SYSTEM

□ Heavy Sleep □ Insomnia □ Wake Easily □ Nightmares □ Difficulty falling asleep □ Difficulty staying asleep

□ Wakes frequently □ Wakes early Time? \_\_\_\_\_\_\_\_\_\_ □ Excess dreaming □ Restless □ Sleep Soundly □ Night sweating □ Snoring □ Sleep Apnea □ Fainting □ Vertigo □ Dizziness □ Tremors □ Fatigue

□ Cold Feet □ Cold Hands □ Swollen Hands/Fee □ Cold Back □ Localized Weakness □ Fevers □ Chills

□ High Blood Pressure □ Low Blood Pressure □ Pain/Pressure Chest □ Irregular Heart Beat □ Palpitations

SKIN/HAIR

□Acne □ Rosacea □ Frequent Rashes □ Eczema □ Hives □ Itching □ Purpura □ Dryness □ Clammy/Moist □ Burning □ Changes in Moles or Lumps □ Bleeds/Bruises Easily □ Varicose/Spider Veins □ Hair Loss □ Dry Scalp □ Change in Hair Texture □Scars Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIGESTIVE SYSTEM

□ Poor Appetite □ Excess Hunger □ Feel tired if miss meal □ Cold Abdomen □ Weight Gain □ Weight Loss

□ Strong Thirst □ For cold? □ For hot? □ Never thirsty □ Crave Sweets □ Crave Salty □ Crave Sour

Specific food craving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Peculiar Tastes or Smells? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Heartburn □ Nausea □ Vomiting □ Belching □ Abdominal Bloating □ Foul Breath □ Stomach Pain

□ Diarrhea □ Constipation □ Flatulence □ Hemorrhoids □ Black Stools □ Bloody Stools □ Mucous Stools

□ Pain/Cramps □ Sensitive Abdomen □ Foul Odor □ Colitis □ Irritable Bowel

BOWEL MOVEMENT: Frequency(#/day) \_\_\_\_\_\_\_\_\_\_ Color\_\_\_\_\_\_\_\_\_\_\_ Quality (loose/firm)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Sudden Energy Drop At \_\_\_\_\_\_\_(time) □ Fatique □ Heavy Limbs □ Weak Limbs □ Restless □ Energetic

URINARY SYSTEM

□ Pain/burning with Urination □ Pain before Urination □ Urgency to Urinate □ Incontinence □ Blood in Urine

□ Kidney Stones □ Frequent Infections □ Strong urine smell □ Frequent Urination: □ Day □ Night

□ Prostate Enlarged □ Elevated PSA □ Impotence Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urine color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEMALE REPRODUCTIVE SYSTEM (Gynecology)

□ Pregnant? # of pregnancies\_\_\_\_\_\_\_\_ # of Deliveries \_\_\_\_ # Miscarriages \_\_\_\_\_\_ # of Abortions \_\_\_\_\_\_\_\_\_\_\_\_

Age Started menstrual cycle\_\_\_\_\_\_\_\_\_ Age Stopped \_\_\_\_\_\_\_\_\_ Last Monthly Period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Period Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Control Method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last PAP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Heavy Flow □ Light Flow Color (pale/dark/red/purple?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Irregular Periods □ Scanty Periods □ Missed Periods □ Painful Periods □ Clots □ Cramps □ Spotting

□ Vaginal Discharges: □Yellow □ White □ Thick □ Thin □ Itching □ Odor □ Breast Lumps □ Breast Pain

□ Menopause □ PMS □ YEAST Infections □ Fibroids □ Endometriosis □ Low Libido

□ Low Backache □ Water Retention □ Hot Flashes Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMOTIONAL & NEUROLOGICAL

□ Seizures □ Tremors □ Numbness/Tingling □ Always Cold □ Always Hot □ Poor Coordination

□ Neuralgia (pain) □ Shingles Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Nervousness □ Depressed □ Anxiety/Worry □ Easily Angered □ Easily Irritated □ Stressed □ Giddy

□ Sadness/Grief □ Frequent Crying □ Mood Swings □ Suicidal □ Phobias/Fears □ Manic □ Panic Attacks

□ Indecisive □ Other Emotional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for completing this confidential, medical history questionnaire. Your honest, complete answers will assist us in providing you with the most holistic health care possible.