Patient Initial Medical/Physical Information

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Filling Instruction: Please try your best to fill out the form below. If possible, please answer most questions with *Yes* or *No*. Thank you for your cooperation. All information is confidential. Total number of pages is 4.

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NAME: _____ **DATE:** _____

Gender: M ___F ___ **Age:** _____ **Date of Birth:** _____/_____/_____(Month/Date/Year)

Home Address: Street: _____

City: _____State: _____Zip-Code: _____

Email: _____

Contact Number: Home: _____Work: _____Cell: _____

Employer: _____ **Occupation:** _____

Emergency Contact: Name: _____ **Relationship:** _____

Contact Number: Home: _____Work: _____Cell: _____

Who referred you for this appointment?

_____

Medical History:

Major Complaints: (Please list them in order of importance.)

1. _____ How Long _____
2. _____ How Long _____
3. _____ How Long _____

Other _____

Personal History:(Please check and list all diseases and surgeries for which you have had in the past.)

□AIDs/HIV	□Alcoholism	□Antibiotic use	□Asthma
□Bleed easily	□Chicken Pox	□Epilepsy	□Glaucoma
□Heart Disease	□High Blood Pressure	□High Cholesterol	□High fevers
□Jaundice	□Kidney Disease	□Measles	□Meningitis
□Mental disorders	□Mumps	□Multiple Sclerosis	□Pacemaker
□Pneumonia	□Polio	□Rheumatic fever	□Rheumatoid Arthritis
□Scarlet fever	□Stroke	□Typhoid fever	□Tuberculosis
□Vascular Diseases	□Venereal Diseases		

□Allergies. If yes, please list what you are allergic to: _____

□Cancer. If yes, please list what cancer you have had: _____On Chemo now _____

□Diabetes: Type 1 ___ or Type 2 ___ □Hepatitis: Type A ___Type B ___Type C ___Other _____

□Thyroid disorders: Hyperthyroidism ___Hypothyroidism ___ □Ulcers. If yes, where: _____

□Surgeries: _____

Other: _____

Family History: (Please check all illnesses which have occurred in any of your blood relatives.)

□Alcoholism	□Allergies	□Bleed easily	□Cancer
□Diabetes	□Epilepsy	□High Blood Pressure	□High Cholesterol
□Heart Disease	□Kidney Disease	□Mental illness	□Obesity
□Stroke			

Other: _____

_____

Medications / Supplements / Drugs

Prescription drugs (Please list all medications you are currently taking.):

1. Name _____Dosage _____Frequency _____For _____
2. Name _____Dosage _____Frequency _____For _____
3. Name _____Dosage _____Frequency _____For _____

4. Name _____Dosage _____Frequency _____For _____
5. Name _____Dosage _____Frequency _____For _____
6. Name _____Dosage _____Frequency _____For _____
7. Name _____Dosage _____Frequency _____For _____
Others: _____
Vitamins/Supplements (Please list all you are currently taking.): _____
_____
Tobacco: Yes ____No____ Amount: _____ In the past:_____
Alcohol: Yes ____No____ Amount: _____ In the past:_____
Caffeine: Yes ____No____ Amount: _____ In the past:_____
Notes: _____
_____

……

Body Temperature

General feeling of Body Temperature: Hot ___Cold ___Neutral ___Whole Body ___Areas _____
Perspiration: More ___Less ___Spontaneous ___Night ____Odor: ***Yes*** ___***No*** ___Other _____
Notes: _____
_____

Diet / Nutrition

What do you eat: _____
What do you not eat: _____
Any food you are allergic to: _____
Appetite: Good ____Strong ____Low ____Feel hungry at time of eating: Often ***Yes*** ____***No*** ____
How does food affect you after you eat: Energized _____Tired _____Gas _____Bloating _____
Temperature preference of food & drink: Cold-side _____Warm-side _____Other_____
Total Daily Liquid Consumption: _____ Thirst level: High ____Normal ____Low ____
Cravings: _____ Any special **Taste** in mouth: ***Yes*** ____***No*** ____What it is_____
Notes: _____

Elimination

Urination: Frequency: ____***/Day*** ____***/Night*** Color: _____Dark ____Light ____ Cloudy____
Urgent ____Burning ____Painful ____ Difficulty ____ Amount: Scanty ____Profuse ____
Notes: _____
_____
Stools: Frequency: ____***/Day*** Complete bowel movement ____ Difficulty ____ Undigested Food ____
Consistency: Formed____ Hard____ Loose ____ Sticky ____Alternating (normal, loose and hard) ___
Smell: Normal ___Strong/foul ___Other: Blood ____Dark red ____Bright red ____Mucous _____
Notes: _____
_____

Sleep

Hours per night: _____ Time to bed: _____Time to wake: _____ Rested when wake up: ____
Trouble falling asleep: ____Racing mind ____ Trouble waking up: ____ Trouble staying asleep _____
Waking at night: _____ Time _____Trouble going back to sleep: _____
Dreams: ____Excessive ____Vivid ____Nightmares ____ Heart Palpitations: ____How often _____
Sweat during sleep: _____
Notes: _____
_____

Energy

Exercise: Type: _____ How often: _____
Level of energy (Scale from 1 to 10): _____ Best time of day: _____ Worst time of day: _____

Notes: _____

_____

Emotions

At this time: _____Stable _____

Significant past emotional states if any: _____

How would you describe your emotions as a child: _____

Notes: _____

_____

Body System Review

Head: Headache: Location _____How often _____Type of Pain _____

Migraine: _____Dizziness: _____ Foggy head _____Heavy head _____

Eyes: Red ____ Itchy ____Watery ____ Blurry ____ Floaters ____ Grit (Discharge from eyes) _____

Decreased Night Vision ____ Glasses or Contacts: _____ For: _____ How Long: _____

Ears: Ringing: _____ Pitch: _____Very Loud _____ Discharge: _____

Nose: Congestion ____Running ____Discharge: Clear ____Yellow ____Bloody ____Other _____

Gums: Bleeding ____Soreness ____Other: _____ **Teeth:** Sensitive _____Cavities _____Loose _____

Throat: Chronic sore throat _____Swollen or sore glands _____Trouble swallowing _____

Chest: Pain ____Oppression or heaviness in the chest: ____Shortness of Breath ____When: _____

Abdomen: Pain: ____Upper ____Lower ____Stomach ____Acid-reflux ____Heartburns ____

Abdominal distension ____Other _____

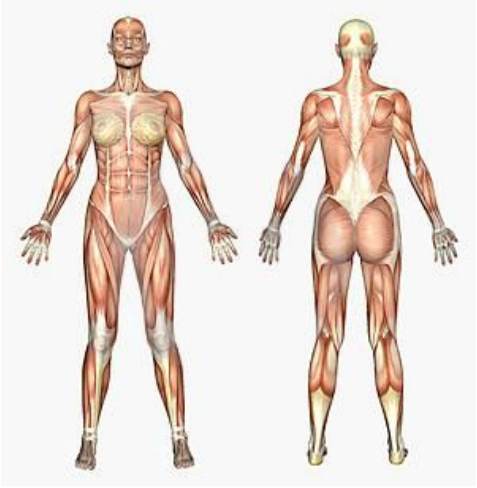
Notes: _____

_____

Joint & Muscle Pain

Joint pain: Finger ____Wrist ____Elbow____Shoulder____Toe ____Ankle ____Knee ____Hip____

Joint swelling: _____



Arm pain ___Leg pain ___Neck/Shoulder Tension ___

Back pain: Upper ___Middle ___Lower ___Sacrum ___

Numbness/tingling in body: _____

Specific Location (if any): _____

Pain is: Constant ____Sharp ____Dull ____Fixed____

Better with: Pressure ____Heat ____Cold ____Rest ____

Movement ____Treatments _____

Or Worse with: Pressure ____Heat ____Cold ____

Rest ____Movement ____Other _____

Notes: _____

_____

_____

Female Only

Menses: Date of last: _____ Age at menarche: _____#Days between cycle: _____

#Days of Flow: _____Light _____Medium _____Heavy _____Color: _____ Clots: _____

Pain or Cramps: _____Before ____During ____After ____Is it better with: Heat _____Pressure_____

Breasts tenderness: ____Irritable: ____Fatigue: ____Cravings: _____Mood changes: _____

Ovulation pain: ____Sexual energy: High ___Average ___ Low ___ Birth control: _____Since _____

Pregnancies: Now Pregnant: ***Yes*** ___***No*** ____Pregnancies in the past ____/Times Premature: _____

Full term: ____ Miscarriage: ____Abortion: ____Diseases during or after: _____

Menopause: ***Yes*** ___***No*** ___Age at onset: ____ Hot Flashes: ____ Night sweat: ____Other _____

Vaginal: Discharge: ***Yes*** ____***No*** ____If yes, When: Daily _____Around period _____Other _____

Color: White ____Yellow ____Both ____Sticky ____Smell: _____Vaginal dryness: _____
Yeast infection: ***Yes*** ___***No*** ___ If yes, Itchiness ____Chronic _____Other _____
Sexual Diseases if any: _____
Notes: _____
_____

Male Only

Prostate: Normal ___Enlarged ___Unknown ___Urination changes _____ Impotence: ***Yes*** ___***No*** ___
Premature ejaculation: ***Yes*** ____***No*** ____ Sexual energy: High ___Average ___ Low ___
Sexual Diseases if any: _____
Notes: _____
_____

Patient Signature: _____Date: _____