Your Name:

Gender Preferred Pronouns SHE/THEY/HE Biological Sex F/M

Marital Status:

Education/Level:

Occupations:

Religion/Spirituality/Community Worship

Heritage, Ethnicity, Race as defined by the Federal Government

* Asian/ or Pacific Islander
* Black/African American
* Hispanic
* American Indian or Alskan Native
* European Heritage
* Other

Primary Health Care Provider/Clinic:

Address:

Phone:

Emergency Contact:

**Main Complaint for today?**

Check all that apply

* …NECK/BACK
* …JOINT PAIN HIP/SHOULDER/KNEE/ELBOW/WRIST/OTHER
* …HEADACHES CHRONIC /(LONGER THAN 6 MONTHS) /ACUTE
* …DEPRESSION/ANXIETY
* …RESPIRATORY PROBLEMS (ASTHMA, ALLERGIES, SINUS CONGESTION)
* …COLD/FLU
* …DIGESTIVE PROBLEMS (POOR APPETITE, HEARTBURN CONSTIPATION)
* …URINARY PROBLEMS (DIFFICULT, PAINFUL URINATION, KIDNEY STONE)
* …FATIGUE, LOW ENERGY, BURN OUT
* …FERTILITY
* …FEMALE REPRODUCTIVE HEALTH (PMS, MENOPAUSE)
* …MALE REPRODUCTIVE HEALTH (ENLARGED PROSTATE, ERECTILE DYSFUNCTION
* …STRESS MANAGEMENT
* …SLEEP, INSOMNIA
* …GENERAL WELLNESS

HEALTH HISTORY

* CANCER
* DIABETES
* INFECTIOUS DISEASE (HEPATITIS, HIV0
* HEART, LUNGS, AND CIRCULATION (ASTHMA, HIGH BLOOD PRESSURE, PREVIOUS HEART ATTACK)
* DIGESTIVE SYSTEM (POOR APPETITE, HEARTBURN, CONSTIPATION, DIARRHEA)
* PSYCHOLOGICAL HEALTH (DEPRESSION, ANXIETY, VIOLENCE TOWARD SELF OR OTHERS
* SKELETON/JOINTS (ARTHRITIS, BACK OR NECK PAIN)
* GENITOURINARY (DIFFICULT, PAINFUL, URINATION, KIDNEY STONES, SEXUALLY TRANSMITTED DISEASE)
* NERVOUS SYSTEM (HEADACHE, DIZZINESS, MULTIPLE SCLEROSIS, PARKINSON’S DISEASE)
* EYES, EARS, NOSE, AND THROAT (LOSS OF VISION, OR HEARING, RINGING IN EARS, SEVERE DENTAL PROBLEM
* SKIN (RASH, SORES, MOLES THAT HAVE CHANGED, ACNE, PIMPLES, EZCEMA, PSOARSIS
* CHRONIC IMMUNE SYSTEM (COLD, FLU, SINUSITIS, BRONCHITIS)
* MEN’S HEALTH PROBLEMS (ENLARGED PROSTATE, ERECTILE DYSFUNCTION)
* WOMEN’S HEALTH (DYSMENORRHEAL, PELVIC INFLAMMATORY, UTERINE FIBROIDS)
* OTHER

Family Health History

Do/Did any members of your immediate family (mother, father, sister, brother) have any serious health conditions or family history of diseases?

* YES. Explain:
* I DO NOT WISH TO REPORT
* NO, I do not know my family’s history

ALLERGIES, Sensitivity to fragrance & perfumes, Essential oils, flowers, foods, smells, irritants

* YES. Please List:
* YES. Do you have an EPI PEN
* NO.

Surgeries, Past, Recent, and future. List Surgery, Date and outcome

Trauma or Injuries, date, severity, treatment and outcomes

Medications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Current Medication | DOSE | PURPOSE | Prescribed by | Date started and how long |
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Fertility/women’s health/women’s reproductive health

Number of Pregnancies

Number of Births

Complications, miscarriage, terminations of pregnancy

**Preventative Health Screenings (check all that apply)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| TIME | Month | 6 months | Year | 5 years | 5+years | NEVER |
| Blood pressure |  |  |  |  |  |  |
| Breast Exam |  |  |  |  |  |  |
| Pap Smear |  |  |  |  |  |  |
| Prostate Exam |  |  |  |  |  |  |
| Colonoscopy |  |  |  |  |  |  |
| Fasting blood glucose |  |  |  |  |  |  |
| Cholesterol |  |  |  |  |  |  |
| Blood Lipids |  |  |  |  |  |  |
| Dental |  |  |  |  |  |  |

Drugs, Caffeine, Alcohol

1. How Often do you typically consume alcoholic drinks (Beer, Wine, Liquor)

* Everyday
* Somedays
* Not at all

1. How Often do you typically consume caffeinated drinks (Coffee, soda, energy drinks)

* Everyday
* Somedays
* Not at all

1. Do you use Tobacco products (chewing, cigarettes, soda)

* Everyday
* Somedays
* Not at all