GENERAL STATUS:

Listed below are factors which may or may not influence your state of being. Please mark the appropriate box signifying their influence.

BETTER	WORSE		BETTER	WORSE	
—	—	Cold	—	—	Heat
—	—	Dampness	—	—	Storms/thunder
—	—	Sun	—	—	Wind
—	—	Open air	—	—	Confined (stuffy air)
—	—	Change of weather	—	—	Moonlight
—	—	Ocean/seashore	—	—	Mountains
—	—	Physical exertion	—	—	Upon rising
—	—	Bath	—	—	Warm applications
—	—	Before menstruation	—	—	During menstruation
—	—	After menstruation	—	—	Tight clothing

SLEEP

Do you have trouble falling asleep? Yes No If yes, what keeps you up?_____
Do you wake in the middle of the night? Yes No If yes, what time is common?_____
Do you wake feeling refreshed? Yes No
Do you have recurring dreams? Yes No If yes, what is the theme? _____

_____
_____
_____

What position do you sleep in? _____
Is there a position you cannot sleep in? Yes No If yes, what is it? _____
Do you stay covered at night? Yes No
Do your feet stick out of the covers? Yes No Sometimes

MENTAL STATUS

Please mark (1) = MILD, (2) = MODERATE, (3) = SEVERE next to the following symptoms which apply to you now or in the past.

NOW	PAST		NOW	PAST	
—	—	Anxiety	—	—	Memory difficulty, forgetful
—	—	Restlessness	—	—	Mental confusion
—	—	Excessive worry	—	—	Decreased concentration, comprehension
—	—	Depression	—	—	Make many mistakes
—	—	Despair/discontent	—	—	Shy, timid
—	—	Suicidal thoughts	—	—	Critical of self
—	—	Suicide attempts	—	—	Critical of others
—	—	Loneliness/feel alone	—	—	Lack of self confidence
—	—	Mood swings	—	—	Suspicious/jealous
—	—	Prefer to be with company	—	—	Sensitive to noise
—	—	Prefer to be left alone	—	—	Organized, neat/clean
		Don't seek out company	—	—	Affectionate
—	—	Afrain when left alone	—	—	Assertive, powerful
—	—	Would rather be left alone	—	—	Confident, secure
		when not feeling well	—	—	Intimate with others

SELF DESCRIPTIONS

Description of childhood. What do you remember from it? What was your nature?

Explain any fears you had during childhood.

List current fears.

What makes you angry? How do you express/relieve it (or not)?

What makes you sad? How do you express/relieve it (or not)?

List experiences of grief/loss in your life and your reaction to them.

Tell me about your work and the level of satisfaction you achieve from it. Any problems?

What do you feel is your mental or emotional limitation?

What in your current behavior would you like to change?

Are you happy/content with your life presently? Please explain as thoroughly as possible.

What do you do for enjoyment/relaxation? Include interests and hobbies.

Write a short description of yourself as you see yourself currently. Include strengths, weaknesses, major personality characteristics.

REVIEW OF SYSTEMS

Please Circle Most Applicable: Y=current condition; N=never had; P=past condition

GENERAL

Weight			
Weight year ago			
Maximum weight			
When			
Height			
Night sweats	Y	P	N
Fatigue	Y	P	N
Date of last physical			

SKIN

Rashes	Y	P	N
Inflammation	Y	P	N
Infection	Y	P	N
Growths	Y	P	N
Changes in hair/nails	Y	P	N

HEAD

Headache	Y	P	N
Head injury	Y	P	N

EYES

Impaired vision	Y	P	N
Eye pain	Y	P	N
Tearing or dryness	Y	P	N
Double vision	Y	P	N

EARS

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache/itch	Y	P	N
Dizziness	Y	P	N

NOSE & SINUSES

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Sinus problems	Y	P	N
Post nasal drip	Y	P	N

MOUTH & THROAT

Frequent sore throat	Y	P	N
Sore tongue	Y	P	N
Sores in mouth/on lips	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental problems	Y	P	N

NECK

Swollen glands	Y	P	N
Pain or stiffness	Y	P	N

BLOOD

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N

RESPIRATORY

Cough	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
• lying down	Y	P	N
• at night	Y	P	N
Positive TB test	Y	P	N

HEART

Heart disease	Y	P	N
High blood pressure	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitations/fluttering	Y	P	N

DIGESTION

Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Stomach pain	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Vomiting	Y	P	N
Bowels (times daily/weekly)			
Loose stools	Y	P	N
Is this a change	Y	P	N
Blood in stools	Y	P	N
Belching/gas	Y	P	N
Liver/gall bladder disease	Y	P	N
Hemorrhoids	Y	P	N

URINARY

Pain on urination	Y	P	N
Increase frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Bladder infections	Y	P	N

CIRCULATION

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N

NEUROLOGIC

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Loss of memory	Y	P	N

continued on reverse side

FEMALE REPRODUCTION

Age menses began	_____		
Number of days menstrual flow	_____		
Length of complete cycle	_____		
Bleeding between periods	Y	P	N
Regular cycles	Y	P	N
Pain during intercourse	Y	P	N
Cramps	Y	P	N
Abnormal vaginal discharge	Y	P	N
Excessive flow	Y	P	N
PMS	Y	P	N
Date of last pap smear	_____		
Abnormal pap	Y	P	N
Date of last menstrual period	_____		
Number of pregnancies	_____		
Number of live births	_____		
Number of miscarriages	_____		
Birth control	Y	P	N
What type	_____		
Difficulty conceiving	Y	P	N
Menopausal symptoms	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N

The following two questions are optional
Sexual preference:
heterosexual ___ bisexual ___ homosexual ___

Number of abortions	_____		

BREASTS

Self exam regularly	Y	P	N
Lumps	Y	P	N
Pain/tenderness	Y	P	N
Nipple discharge	Y	P	N

EMOTIONAL

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety/nervousness	Y	P	N
Tension	Y	P	N

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N
Broken bones	Y	P	N
Muscle spasms/cramps	Y	P	N
Weakness	Y	P	N

MALE REPRODUCTION

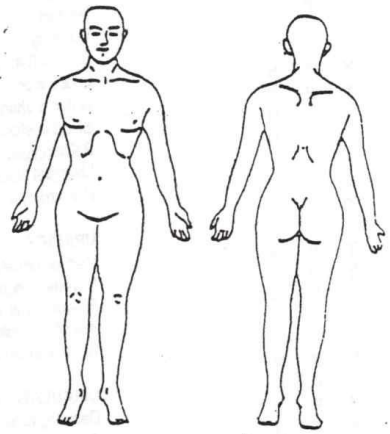
Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate problems	Y	P	N
Venereal disease	Y	P	N
Discharge/sores	Y	P	N
Difficulty starting/stopping urination	Y	P	N
Birth control	Y	P	N
What type	_____		

The following question is optional
Sexual preference:
heterosexual ___ bisexual ___ homosexual ___

ENDOCRINE

Thyroid problem	Y	P	N
Heat/cold intolerance	Y	P	N
Hypoglycemia	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Easy weight gain	Y	P	N

Indicate on diagram any problem areas:



Insurance Information

Insurance Company _____ Certificate/Group # _____
Address _____ Subscriber _____
_____ Subscriber SS # _____
Telephone _____ Patient/Subscriber Relationship _____

In your opinion, what are your most important health concerns? Please list most immediate concerns first.

Onset	Complaints	Treatment/Resolved

Date	Hospitalizations/Operations/Traumas/Accidents/Major Illnesses

Date	Medications/Vitamins/Herbs	Dosages

YOUR HEALTH HISTORY:

Now	Past	Never	Relative	
—	—	—	—	Anemia
—	—	—	—	Arthritis
—	—	—	—	Acoholism
—	—	—	—	Asthma
—	—	—	—	Bleeding
—	—	—	—	Cancer (type)
—	—	—	—	Colitis
—	—	—	—	Heart murmur
—	—	—	—	Headache
—	—	—	—	Pneumonia
—	—	—	—	Kidney disease
—	—	—	—	Liver disease/jaundice
—	—	—	—	Overweight
—	—	—	—	Tuberculosis
—	—	—	—	Venereal (type)

Now	Past	Never	Relative	
—	—	—	—	Diabetes
—	—	—	—	Hypoglycemia
—	—	—	—	Allergies
—	—	—	—	Candida (yeast)
—	—	—	—	Emphysema
—	—	—	—	Eczema/skin disorders
—	—	—	—	Drug/Alc. use (specify)
—	—	—	—	High blood pressure
—	—	—	—	Injury
—	—	—	—	Rheumatism
—	—	—	—	Thyroid (hyper or hypo)
—	—	—	—	Ulsers
—	—	—	—	Mononucleosis
—	—	—	—	Nervous breakdown
—	—	—	—	Other (specify)