MEDICATION/SUPPLEMENTS

Name Dosage Date started Reason

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

attach more as needed

HEALTH SCREENING HISTORY

List the date/year of your most recent test or exam.

Mammogram:_____ Thermogram:_____ Pap Smear:_____ Breast Exam by Doctor:_____

OBGYN/Pelvic Exam:_____ Blood test (what for):_____

Prostate/Rectal Exam:_____ Self Testicle Exam:_____ Testicle Exam by Professional:_____

Test for Blood in stool:_____ Colonoscopy:_____

Immunizations: Polio:_____ Tetanus:_____ Hepatitis:_____ Pneumonia:_____ Flu Shot:_____

Physical Exam:_____ X-Ray:_____

Chiropractic treatment: _____ Acupuncture treatment:_____ Physical Therapy:_____

Are you under the care of a physician? If yes, for what? _____

Do you have any other health conditions you have been treated for in the past 10 years? (list below)

_____

_____

_____

Healing Traditions

Check Boxes Below

Habits	None	Light	Mod.	Heavy	**Comments if any.**
Alcohol					
Coffee					
Tea					
Soda					
Tobacco					
Medication Drugs					
Recreational Drugs					
Exercise					
Sleep					
Appetite					
Soft Drinks					
Water					
Salty Foods					
Fried Foods					
Milk					
Cheese					
Gluten					
Grains					
Corn					
Soy					
Refined White Sugar					
Natural Sugars- honey, maple syrup, etc.					
Artificial Sweeteners- Stevia, Truvia, Splenda, Equal, SweetNlow, xylitol					

What is your **energy** level on a scale from 0-10 (10 being highest): _____ / 10

What do you remember most?
☐ What you **SEE** ☐ What you **HEAR** ☐ What you **FEEL/TOUCH/INTERACT WITH**

The main reason I brush my teeth is to:
☐ Avoid tooth decay and gum disease ☐ Have healthy teeth and gums

When I make ***decisions*** I generally:
☐ Gather facts and weigh the evidence ☐ Decide quickly on a best choice
☐ Consult my friends and family ☐ Base decisions upon how I *feel* about it

Patient's Last Name	First

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SENSITIVE HEALTH INFORMATION

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your case. Please complete as accurately as possible.

History of smoking cigarettes, cigars, or chew tobacco? Yes / No
If yes, how much? _____ For how many years? _____

History of alcohol use? Yes / No If yes, what kind/s? _____
If yes, how much? _____ For how many years? _____

History of recreational drug use? Yes / No If yes, what kind/s? _____
If yes, how much? _____ For how many years? _____

Have you been diagnosed with a mental illness? Yes / No Diagnosis: _____
If yes, treatment? _____

Have you ever been tested for the HIV virus? Yes / No Results? _____

Have you ever been diagnoses with HIV or an HIV related illness? Yes / No
If yes, what type of treatment are you under, if any? _____

When is the last time you were tested for any STD's? _____ Results? _____
If so, when/what was the treatment? _____

MENTAL/EMOTIONAL HEALTH HISTORY

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could possibly imagine and 1 being relatively no stress.

Please circle the appropriate number:	Low									High
Financial/Money Matters	1	2	3	4	5	6	7	8	9	10
Relationship/Family	1	2	3	4	5	6	7	8	9	10
Job/Career/Education	1	2	3	4	5	6	7	8	9	10
Current level of health	1	2	3	4	5	6	7	8	9	10
Spiritual/Religious	1	2	3	4	5	6	7	8	9	10
Ethical/Moral	1	2	3	4	5	6	7	8	9	10
Overall level of life stress	1	2	3	4	5	6	7	8	9	10

Please check all of the following life events that you currently (or previously) experience stress with:

- ☐ Birth of siblings
- ☐ Toilet training
- ☐ Babysitters
- ☐ Death of a pet/pet health
- ☐ School
- ☐ Teachers
- ☐ Friends
- ☐ Colleagues
- ☐ Fights
- ☐ Onset of puberty
- ☐ Romance
- ☐ Illness/operations
- ☐ Parental conflict/separation
- ☐ Divorce
- ☐ Dating
- ☐ College
- ☐ Abortion/Miscarriages
- ☐ Infertility
- ☐ Any betrayal
- ☐ Marriage
- ☐ Moving
- ☐ Traveling
- ☐ Accidents
- ☐ Loss of job/layoff
- ☐ Financial disruptions
- ☐ Illness of a loved one
- ☐ Diagnosis of a fatal condition
- ☐ Death of a loved one
- ☐ Other: _____