GLOBAL CONSCIOUS SOLUTIONS, LLC

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Please take the time to answer as honestly and completely as possible. The goal of these questions is to get your health history and to look for clues to the root cause of your problem. If needed, please use additional paper or space for your answers.

Name:____ Date:________________

Date of birth________________________ Age:________ SS#:______________________

Address: ____

City:______________________________ State:__________ Zip:____________________

Phones: Home: _______________________________ Cell: _______________________

E-mail address:____

Name of Spouse/Legal Guardian (circle one) ____

Marital Status: Single Married Divorced Separated w/Partner Widow(er)

Emergency Contact _____________________________ Phone: __________________________

Other Physicians you currently see: ____
____

I authorize employees or agents of Global Conscious Solutions, LLC to leave a detailed message for me on a voice message device associated with the phone number listed above regarding my:
Laboratory reports YES _________ initials NO _________ initials
Protected health information YES _________ initials NO _________ initials

If you answered NO to either of the above, the physicians and/or staff members at Global Conscious Solutions, LLC will, as necessary, leave a message indicating your need to call us to retrieve any of your health-related information.

Whom can we thank for referring you? ____

Please list any drug, herb or food allergies and your reaction:

List, in order of importance, your goals for working with the doctor/s at Global Conscious Solutions, LLC:

1. ____
2. ____
3. ____
4. ____
5. ____

What symptoms do you experience on a continual basis? ____
____

When did this start? ____

What was happening in your life at this time? ____

What have you tried as treatment for this? ____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	______	______	______	______	______	______
Age when died:	______	______	______	______	______	______
Reason for death:	______	______	______	______	______	______
Cancer type:	______	______	______	______	______	______
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

Is there anything else you would like to share about your family's medical history?
____

Health and Medical timeline

List All Surgeries & Hospitalizations, including date occurred:

1. ____
2. ____
3. ____
4. ____
5. ____

Please note when and/or why you have had or were diagnosed using any of the following:

X-Rays: ____________________ MRI/CAT Scan: ____________________
Ultrasounds: ____________________ Accidents: ____________________
TB Test: ____________________ HCV: ____________________
HIV: ____________________ Flu Shot: ____________________
Last Dental Visit: ____________________ Last eye exam: ____________________

Please mention from birth to the present day all important or significant events (emotional and physical traumas, heartbreak, divorce, work related stresses, disappointments, moves, family stresses, death of friends and family, etc.). Use as much space as you like: ____________________
____
____
____
____

Did you have the following Disease (D), Been Vaccinated (V), or Neither (N):

Measles	D	V	N	Hemophilia	D	V	N	Rubella	D	V	N
Mumps	D	V	N	Chicken Pox	D	V	N	Tetanus	D	V	N
Hep B	D	V	N	Whooping Cough	D	V	N	Rubeola	D	V	N
HIB	D	V	N								

Any vaccination reactions?
____

List Yes (Y), No (N), or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Coffee: Y N P Cups per day if Yes: __________

Analgesics: Y N P Laxatives: Y N P Tea: Y N P Cups per day: ________________

Smoking: Y N P Packs per day & number of years: ___________

Soda/Pop: Y N P Ounces or cans per day if Yes: _____________

Alcohol: Y N P How often & how much if Yes: _____________

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P
Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

List all Prescription Medicines & Supplements/Herbs that you are taking and include dosage if known:
____
____
____
____
____
____

Present Weight: ________________Height: ____________Weight one year ago: ________________
Maximum weight and when: _______________ Minimum weight as adult & when: _______________
Any weight questions or concerns?
____

Regarding the next long section: Please circle (Y) if you currently have the problem, (N) if you've never had the problem and (P) if you had the problem in the past.

Good Energy: Y N P Fatigue: Y N P
If you have fatigue when is it the worst?
____
If you have fatigue, can you do what you need to during the day? YES NO

Review of Body Systems

SKIN

Rash:	Y N P	Color Change:	Y N P
Hives:	Y N P	Lump:	Y N P
Psoriasis/eczema:	Y N P	Itchy:	Y N P
Dry:	Y N P	Warts/moles:	Y N P
Cancer:	Y N P	Perspiration:	Y N P

HEAD

Headache:	Y N P	Migraine:	Y N P
Dandruff:	Y N P	Head Injury:	Y N P
Oil/Dry Hair:	Y N P	Hair Loss:	Y N P

NOSE

Frequent Colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post Nasal Drip:	Y N P
Polyps:	Y N P	Seasonal Allergies:	Y N P

EYES

Dry/Watery:	Y N P	Blurry Vision:	Y N P
Double Vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P

Itchy:	Y N P	Dark Under Eyelid:	Y N P

MOUTH/THROAT

Canker Sores:	Y N P	Cold Sores:	Y N P
Sore Throat:	Y N P	Gum Disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of Taste:	Y N P	Hoarseness:	Y N P

NECK

Stiffness:	Y N P	Swollen Glands:	Y N P
Full Movement:	Y N P	Tension:	Y N P

RESPIRATORY

Cough:	Y N P	TB:	Y N P
Shortness of breath w/exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P	Rheumatic Fever:	Y N P
Low Blood Pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest Pain:	Y N P

URINARY TRACT

Incontinence:	Y N P	Pain w/Urination:	Y N P
Frequent Infections:	Y N P	Kidney Stones:	Y N P
Urgency:	Y N P	Discharge/Blood:	Y N P

GASTROINTESTINAL

Heartburn:	Y N P	Bowel Movement Freq:	/day
Indigestion:	Y N P	Recent BM Change:	Y N P
Bloating:	Y N P	Diarrhea/Constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall Bladder Disease:	Y N P
Change In Appetite:	Y N P	Liver Disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

How many times have you used antibiotics? ____

MALE

Testicular pain/swelling:	Y N P	Sexually Active:	Y N P
Hernia:	Y N P	S.T.D.:	Y N P
Discharge:	Y N P	Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P	Sexual Orientation:	Hetero Homo Bi

FEMALE

Age Period Began:		How Often Period Occurs:	
How long period lasts:		Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P	Menstrual Pain:	Y N P
PMS:	Y N P	Food cravings:	Y N P
Times Pregnant:		How many births:	
Miscarriages:		Abortions:	
Last Pap Smear:		Diagnosis:	
Any abnormal paps:	Y N P	When was abnormal:	
Menopausal since what age:		Use of hormones:	Y N P
Type of hormones used:		Healthy libido:	Y N P
Dry vagina:	Y N P	Sexually Active:	Y N P
Pain w/intercourse:	Y N P	Vaginitis:	Y N P
S.T.D.:	Y N P	Mammography: If Yes, what were results?	Y N P
Dexa Scan: If yes, what were results?	Y N P	Sexual Orientation:	Hetero Homo Bi

List any birth control used, age used and length of time used:
____
____

MUSCULOSKELETAL

Weakness:	Y N P	Arthritis:	Y N P
Stiffness:	Y N P	Leg Cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P

NERVOUS SYSTEM

Paralysis:	Y N P	Sciatica:	Y N P
Tingling/numbness:	Y N P	Carpal tunnel syndrome:	Y N P
Seizures:	Y N P	Fainting:	Y N P

MENTAL/EMOTIONAL PATTERNS

What do you tend to worry about?____
How easily do you cry?____
Do you have any recurrent dreams? Y N
What is their theme?____
What would you like to change most about yourself?____
What do you need to feel happy?____

Please list how often you experience the following emotions, (R) rarely, (O) occasionally, (F) frequently

Joy	R O F	Anxiety	R O F
Fear	R O F	Timidity	R O F
Anger	R O F	Sadness	R O F
Jealousy	R O F	Fright	R O F
Hate	R O F	Despair	R O F
Frustration	R O F	Worry	R O F

Of those emotions, which are hard for you to deal with? ____
How often do you think about past events or situations? ____
What would you ideally like to do for a living? ____
What troubles you most about your primary concern? ____
When is the last time you felt good? ____

Do you experience any of the following? (Y) yes, (N) no, (P) past

Depression:	Y N P	Anger/irritability:	Y N P
Suicidality:	Y N P	High-strung/tense:	Y N P
Anxiety:	Y N P	Fear/Panic:	Y N P
Eating disorder:	Y N P	Psych Hospitalization:	Y N P

EXERCISE

How often do you exercise?
____
What type of exercise?
____
For how long?
____

SLEEP PATTERNS

How many hours per night? __________ Do you wake at any particular times? ___________
If you wake up frequently, what is the reason? _____________________________________
How do you feel in the morning? ____
When is your energy the best? ____
When is your energy the lowest? ____

Nightmares:	Y N P	Wake Refreshed:	Y N P
Sleep Walk:	Y N P	Grind teeth:	Y N P
Must nap during the day:	Y N P	Snore:	Y N P

TOXIN EXPOSURE

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution?____
____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? Y N

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing/ home remodeling? Y N

Are you particularly sensitive to perfumes, gasoline or other vapors? Y N

How sensitive are you to medications or anesthesia? ____

Do you use pesticides, herbicides or other chemicals around your home? Y N

SOCIAL INFORMATION

What is your occupation? ________________________

Do you enjoy your job? __________________________ Hours worked per week: ___________________

Highest Level of Education: _______________________ Active spiritual practice: Y N P

Quality of significant relationship:____

History of sexual, mental/emotional, physical abuse: Y N P

If so, at what age and by whom: ____

How often do you get sick with the cold or flu? ____

What is your typical daily routine?

____

What hobbies or other interests do you have?

____

How much water do you drink in a day? ____

What do you do to relax? ____

Food Information

List your ideal diet- Breakfast, Lunch, Dinner: ____

____

List your typical diet- Breakfast, Lunch Dinner: ____

____

If they are mismatched, how can your ideal become your typical? ______________________________

How often do you snack? ____

How do you feel after meals? ____

What foods do you dislike and refuse to eat? ____

What foods do you react to negatively? ____

What foods do you crave? ____

Thank you for taking the time to fill out this long document. Your answers here will help provide the best care possible for overall health, wellness and longevity.