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This information is confidential and will only be released with your signed consent.

Date: ______________________________________Phone:____

Email: ____

Name: ____

Address: ____

Emergency Contact: ____Relationship: ________________________

Emergency contact Phone: ______________________________________Email: _________________________________

Occupation: ____

Birthdate: ____________________________Age: _________Sex: _______Ht: ______Wt: _________________________

Referred by: ____

What would you like to accomplish today?

____

____

____

____

Describe what you do most every day. What is a typical day?

____

____

____

____

Are you typically Hot or cold? ____

Do you prefer salty foods or sweet foods? ____

What do you eat during the week for breakfast? ____

Lunch?____

Dinner?____

Snacks? ____

Favorite foods? ____

____

Do you consider yourself someone with a lot of energy? ____

Do you wish you had more energy? ____

How long do you sleep at night? ____

Do you wake often in the night? ____

What time(s) of the night/morning do you wake? ____

Do you take any medications? If Yes, please list. ____

____

____

Have you ever taken Homeopathic remedies? If so, what did you take? ___________________________________

Have you ever taken Chinese Herbs? If so, what did you take? ___________________________________

Do you take vitamins? If yes, what and which brands? ____

____

How often do you eat organic food? ____

Medical History

Illness/operation	Date started (approx)	How often?	Mild/Moderate/Severe

Family History

Please describe illnesses that your Mother has had: ____

____

____

If deceased, cause of death: ____

____

Please describe illnesses that your Father has had: ____

____

____

If deceased, cause of death: ____

____

Please describe illnesses that your Siblings have had: ____

____

____

If deceased, cause of death: ____

____

Please describe illnesses that your significant other has had: ____

____

____

If deceased, cause of death: ____

____

Circle any items that apply to you and your blood relatives and state relationship
Example: Alcohol/drug problem Father, mother

Alcohol/Drug Problem	Heart disease
Allergies	High Blood Pressure
Asthma	High cholesterol
Anemia	Kidney Disease
Arteriosclerosis	Liver Disease
Arthritis	Obesity
Bing eating/Bulimia	Paralysis
Cancer	Skin disease
Bleeding Tendency	Stroke
Depression	Suicide
Diabetes	Thyroid Disease
Epilepsy/Seizures	T.B.
G.I. disease	STD
Dizziness	Conjunctivitis
Acid Reflux	IBS
Osteoporosis	Parkinsons
Alzheimers	Senility
Bone Fractures	Mental Illness
Other:	

Please review the following and circle yes or no if you are currently having any of these symptoms

Yes	No	Cardiovascular (chest pain, fainting)
Yes	No	Respiratory (wheezing, shortness of breath)
Yes	No	Metabolic (thyroid disorder, abdnormal blood sugars, fevers)
Yes	No	Neurological (headaches, numbness, dizziness)
Yes	No	Gastrointestinal (diarrhea, constipation)
Yes	No	Skin (rashes, acne, eruptions)
Yes	No	Musculoskeletal (joint pain, muscle pain, spasms)
Yes	No	Ear, nose throat (infections, allergies, congestion)
Yes	No	Vision (blurred, seeing spots)
Yes	No	Sexual function (poor desire, trouble with orgasm)
Yes	No	Urinary (kidney stones, frequent urination, incontinence)
Yes	No	Mental/emotional (panic attacks/unusual fears, sad)
Yes	No	Sleep (insomnia, sleep apnea)

For Women:

What age did menstruation begin? ____

Usual length of cycle?____

Describe cycle: ____

Number of pregnancies:____

Number of Abortions, miscarriages:____

Age at menopause____

Other:____

Please describe your mental/emotional state during pregnancy, delivery, any traumas, natural birth, etc.:

____

____

____

What are your favorite books/movies?

____

____

____

FOR CHILDREN:

Please draw a picture of yourself or your favorite thing to do or someone you love.