|  |  |
| --- | --- |
| Name |  |
| Date |  |
| Occupation |  |
| Education |  |
| Date of Birth |  |
| Age |  |
| Gender |  |

**Family History**

|  |  |  |
| --- | --- | --- |
|  | Age | If deceased, cause of death |
| Father |  |  |
| Mother |  |  |
| Siblings |  |  |
| Children |  |  |

**Check Items that apply to blood relatives, and list relationship.**

|  |  |
| --- | --- |
| Alcohol/Drug abuse | Gonorrhea |
| Allergy/Asthma | High Blood Pressure |
| Anemia  | Kidney Disease |
| Arteriosclerisis | Liver Disease |
| Arthritis | Mental Illness |
| Bing eating/Bulimia | Obesity |
| Bleeding Problem | Stroke |
| Cancer | Suicide |
| Diabetes | Thyroid Disease |
| Epilepzy/Seizure | Tuberculosis |
| Heart Disease | Ulcer |
| Skin Disease | Syphilis |

**Please check or highlight all that apply to you and list approximate dates.**

|  |  |  |
| --- | --- | --- |
| Acne | Endometriosis | Panic attacks |
| Aids | Fibroids (Uterine) | Pelvic infections |
| Alcohol/drug adiction | Gallbladder | Peridontal disease |
| Allergies | Glaucoma | Phlebitis |
| Anemia | Gout | Pneumonia |
| Antibiotics | Hearing issues | PMS |
| Anorexia/bulimia | Heart attack | Prostate issues |
| Anxiety | Heart failure | Psychotherapy |
| Arthritis | Hemorrhoids | Rheumatic fever |
| Asthma | Hepatitis | Scarlet fever |
| Back issues | Herpes | Seizuers/epilepsy |
| Bing eating | Hernia | STIs |
| Bladder infections | High blood pressure | Sinusitis |
| Blood clots | Hives | Sleep disorder |
| Breast lumps | Insomnia | Steroid use |
| Bronchitis | Kidney issues | Stroke |
| Cancer | Liver issues | Suicidal inclinations |
| Cataracts | Menstrual issues | Syphilis |
| Chemical sensitivity | Mental illness | Thyroid issues |
| Chronic fatigue | Migrianes | Tuberculosis |
| Colitis | Mononeucliosis | Ulcers |
| Depression/anxiety | Mumps | Vaccine reactions |
| Diabetes | Neurological issues | Warts |
| Ear infections | Nightmares |  |
| Eczema | Overweight |  |

|  |
| --- |
| **Surgery**: List all procedures and approximate dates |
| **Accidents, Traumatic Injuries, Broken Bones:** |

**Male**

|  |
| --- |
| Date of last menstrual period: |
| Length of period |
| Length of period |
| Menopause? |
| Number of pregnancies |
| Number of live births |
| Number of abortions/miscarriages |
| Vaginal discharge? |
| Spotting between periods? |
| Painful intercourse? |
| Issues with fertility? |
| Problems with sexual function? |

**Lifestyle**

|  |  |
| --- | --- |
| **Prescription Medications (List prescribing doctor)** | **Vitamins/Mineral Supplements** |
| **Allergies** | **Food Allergies (include method of testing)** |
| **Food Cravings** | **Alcohol/Recreational Drug Use**Do you drink alcohol or use drugs?How much/often? |
| **Caffeine**Do you drink coffee or tea?How much/often? | **Cigarettes**Do you smoke now or did you in the past?How much/often? |
| **Diet Soda/Artificial Sweeteners**Describe your use: | **Refined Sugars/Processed Foods:**Describe your use: |
| **Hobbies**How often do you do them? | **Living Situation** |

|  |  |
| --- | --- |
| **Exercise:** Describe the ways you get your body moving. Do you feel you get enough physical activity? | **Food:** Do you feel you eat a healthy and well-balanced diet? Do you need guidance/support? |
| **Worry/Anxiety:** Do you have particular issues that worry you? How does this impact your life?  | **Healthy Relationships:** Do you have a supportive family/community? |
| **Unhealthy Relationships:** Have you been a victim of domestic abuse or troubling relationships? | **Spiritual Life:** Do you have a spiritual practice? Is your spiritual life fulfilling and satisfactory? |

**Life Changes**

In the past year, what changes have occurred in your:

|  |
| --- |
| **Personal Life:** |
| **Family Life:** |
| **Social Life:** |
| **Work Life:** |

Anything else you would like to add?