NEW PATIENT INFORMATION Name_____ Date_____

What are your major complaints? _____

_____

When did it start and what therapies have you tried for it? _____

_____

List all medications currently taking: _____

_____

List all supplements currently taking: _____

_____

Are there any **foods** or **supplements** that you don't/want to take? _____

_____

Are you vegetarian? YES (type _____) NO Are you pregnant or trying to be? YES NO

What diseases run in your family? (Specify which family member(s)): _____

_____

Mark "**C**" or check mark **Current** problems and "**P**" by problems you've had in the **Past**:

Sinus-chronic congestion or infection _____
Headaches (how often) _____
High or Low blood pressure (circle one)_____
High cholesterol _____
Vision (near or far sighted) _____
Fatigue _____
Digestion:
Gas _____
Bloating _____
Heartburn/reflux _____
Diarrhea _____
Constipation _____
Nausea or vomiting _____
Abdominal pain or cramping _____
Skin Problems:
dry/oily skin _____
acne _____
psoriasis or eczema _____
skin cancer _____
white patches _____
dry, brittle hair or nails _____
warts _____
Other skin issues _____
Cold hands or feet _____
Difficulty going to sleep _____
Difficulty staying asleep _____
Difficulty getting up in morning _____
Tendency to have intense dreams or no dreams _____
Anxiety, restlessness _____
Heart racing, palpitations _____
Joint pain (where?) _____
HIV positive _____
Hepatitis (type) _____
Herpes (type) _____
Arthritis _____ Joints affected _____
Circle Type: Rheumatoid, Osteo, Degenerative Psoriatic
Gout _____
Back or Joint Pain (where?) _____
TMJ problems _____
Fibromyalgia _____
Do you have any metal in your body? Where? _____
List below any trouble you've had in the past with taking **any** nutritional or pharmaceutical products:

Frequent infections or colds _____
Ear infections _____
Last antibiotics taken when? _____
High or Low blood sugar _____
Varicose veins _____
Female:
Last menstrual period was _____
Days in cycle (Avg 28 days) _____
Fibrocystic breasts _____
Cramping or Headaches with cycle ____
Premenstrual tension _____
Excessively heavy periods _____
Excessively painful periods _____
Cervical erosion _____
Any pelvic cancer?(type) _____
Abnormal PAP (when?) _____
Uterine or ovarian cysts _____
Loss of Libido _____
Bladder control problem _____
Endometriosis _____
Hot flashes _____
Male:
Prostate Hyperplasia _____
Difficult or freq. Urination _____
Impotence _____
Loss of Libido _____
Other ____ _____
Auto Immune Conditions:
MS _____
Hashimoto's _____
Raynaud's _____
Lupus _____
Other: _____
Allergies _____
Tumors or Cysts (where?) _____
Surgeries _____
Date of last physical with blood values ___
_____
Blood type _____

List amounts normally ingested:
Water _____ounces per day
Coffee _____cups per day/week
(regular or decaffeinated?)
Tea _____cups per day/week
Soda _____oz. per day/week
Juice _____oz per day/week
Alcohol _____drinks per day/week
Sweet Treats _____ per day/week
(most common type?_____)
Average number of air travel flights per year _____

Smoking History_____

_____

What is a normal BREAKFAST for you?

What is a normal LUNCH for you?

What is a normal DINNER for you?

What are common snacks for you?

Average exercise?
_____ hours per day/week

Please list all other significant health related events and other diagnoses you have been given below:
_____