



8. **Family History:**

Father

Mother

Brothers

Sisters

Spouse

Children

Check those applicable:

Age (if living) \_\_\_\_\_

Health (G=Good, P=Poor) \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Stroke \_\_\_\_\_

Mental Illness \_\_\_\_\_

Asthma/Hay fever/Hives \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Age (at death) \_\_\_\_\_

Cause of Death \_\_\_\_\_

9. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever

Diphtheria

Rheumatic Fever

Mumps

Measles

German Measles

Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio

Tetanus

Rubella/Mumps/Rubella

Pertussis

Diphtheria

Hib

Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

Reason

When

Reason

When

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason

When

Reason

When

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. **Emotional** (please circle any that you experience now or have experienced in the past):

Mood Swings      Nervousness/Anxiety      Mental Tension      Depression      Fear  
Frustration      *Panic Attacks*

16. **Energy and Immunity** (please circle any that you experience now or have experienced in the past):

Fatigue      Slow Wound Healing      Chronic Infections      Chronic Fatigue Syndrome  
*Auto immune disease*      *Allergies*

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now or have experienced in the past):

Impaired Vision      Eye Pain/Strain      Glaucoma      Glasses/Contacts      Tearing/Dryness  
Impaired Hearing      Ear Ringing      Earaches      Headaches      Sinus Problems  
Nose Bleeds      Frequent Sore Throats      Teeth Grinding      TMJ/Jaw Problems      Hay Fever

18. **Respiratory** (please circle any that you experience now or have experienced in the past):

Pneumonia      Frequent Common Colds      Difficulty Breathing      Emphysema  
Persistent Cough      Pleurisy      Asthma      Tuberculosis  
Shortness of Breath      Other Respiratory Problems: \_\_\_\_\_

19. **Cardiovascular** (please circle any that you experience now or have experienced in the past):

Heart Disease      Chest Pain      Swelling of Ankles      High Blood Pressure  
Palpitations/Fluttering      Stroke      Heart Murmurs      Rheumatic Fever      Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now or have experienced in the past):

Ulcers      Changes in Appetite      Nausea/Vomiting      Epigastric Pain      Passing Gas      Heartburn  
Belching      Gall Bladder Disease      Liver Disease      Hepatitis B or C      Hemorrhoids      Abdominal Pain  
*Diarrhea Constipation IBS Crohns*

21. **Genito-Urinary Tract** (please circle any that you experience now or have experienced in the past):

Kidney Disease      Painful Urination      Frequent UTI      Frequent Urination      Heavy Flow  
Kidney Stones      Impaired Urination      Blood in Urine      Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now or have experienced in the past):

Irregular Cycles      Breast Lumps/Tenderness      Nipple Discharge      Heavy Flow  
Vaginal Discharge      Premenstrual Problems      Clotting      Bleeding Between Cycles  
Menopausal Symptoms      Difficulty Conceiving      Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_      4. Birth Control Type: \_\_\_\_\_      7. # of Abortions: \_\_\_\_\_  
2. # of Days of Menses: \_\_\_\_\_      5. # of Pregnancies: \_\_\_\_\_      8. # of Live Births: \_\_\_\_\_  
3. Length of Cycle: \_\_\_\_\_      6. # of Miscarriages: \_\_\_\_\_

24. **Male Reproductive** (please circle any that you experience now or have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now or have experienced in the past):

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

26. **Neurologic** (please circle any that you experience now or have experienced in the past):

Vertigo/Dizziness      Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now or have experienced in the past):

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

28. **Other** (please circle any that you experience now or have experienced in the past):

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

29. **Lifestyle:**

a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

e. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other

f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y / N      Why/Why not? \_\_\_\_\_

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

h. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_  
\_\_\_\_\_

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

j. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

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