Healing Intentions

Healing Starts When Intentions Begin

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization

Name: _____ Today's Date: _____

Address: _____

City: _____ Birth Date: _____ Age: _____

State: _____ Zip: _____ Place of Birth: _____

Phone (home): (_____) _____ Phone (cell): (_____) _____

Your Doctor's Name: _____ Occupation: _____

Specialty: _____ Employer: _____

Phone: (_____) _____ Referred by: _____

Reason(s) for your visit: _____

_____

Date of onset (when you first noticed your problem): _____

Other complaints: _____

_____

Family History Complete for each family member: Place an X in the box, indicating any of the illnesses that they have had.

	Self	Mother	Father	Siblings	Children	Grand parents
Arthritis						
Asthma						
Allergies						
Heart trouble						
Anemia						
Depression						
Cancer						
Drug abuse						
Epilepsy						
Stroke						
Kidney/Bladder trouble						
Gallstones						
Ulcers						
High Blood Pressure						
Chronic Fatigue						
Hepatitis						
Jaundice						
Diabetes						
Other (please specify)						
Age of Death						

Healing Intentions
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Major Hospitalizations If you have ever been hospitalized for any operation or serious medical illness, write in your most recent hospitalizations below. Do not include normal pregnancies.

Year	Operation or Illness

Medicines Mark an X in the box next to any of the following that you are now taking.

☐ aspirin	☐ ibuprofen	☐ acetaminophen (Tylenol)	☐ antacids
☐ laxatives	☐ cold tablets	☐ oral contraceptives	☐ diet pills
☐ tranquilizers	☐ fiber supplements	☐ sleeping pills	☐ hay fever tablets

Vitamins (please list): _____

Herbs (please list): _____

Other medications: _____

ALLERGIES: _____

Habits Please indicate all of the habits listed below which apply to you now or did in the past.

coffee: ☐ yes ☐ no cups per day/week: _____ age started: _____ age quit: _____

tobacco: ☐ yes ☐ no # cigarettes per day: _____ age started: _____ age quit: _____

marijuana: ☐ yes ☐ no uses per day/week: _____ age started: _____ age quit: _____

alcohol: ☐ yes ☐ no uses per day/week: _____ age started: _____ age quit: _____

other: _____ age started: _____ age quit: _____

Previous Pregnancies Please fill in completely.

Year	Length of pregnancy	Labor hours	Type of delivery	Sex	Weight	Name

Total pregnancies (including miscarriages or abortions)_____

Nutrition **Food allergies:** ☐ Yes ☐ No If yes, to what? _____

Do you frequently: ☐ Skip breakfast ☐ Eat a late dinner (ie. close to bedtime)

How many meals a day do you eat? _____When is your biggest meal? _____

Do you frequently eat when you are worried or rushed? ☐ Yes ☐ No

How many glasses of water do you drink a day? _____

Exercise Type_____ Frequency _____

Stress ☐ None ☐ Moderate ☐ Severe What causes it? _____

History of positive testing (self or partner)

☐ HIV ☐ TB ☐ Gonorrhea ☐ Hepatitis ☐ Chlamydia ☐ Herpes: oral/genital

☐ Genital warts ☐ Syphilis

Emergency Contact Name: _____ Phone: (____)_____ Relationship: _____

Patient's signature: _____ **Date:** _____

REVIEW OF SYSTEMS

Place a check mark next to those symptoms that are current conditions

HEAD
- ☐ Dizziness
- ☐ Fainting
- ☐ Neck Stiffness
- ☐ Enlarged lymph glands
- ☐ Frequent headaches
- ☐ Loss of balance
- ☐ Other: _____

EARS
- ☐ Infection or itchy
- ☐ Ringing
- ☐ Decreased hearing
- ☐ Earaches
- ☐ Other: _____

EYES
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Poor night vision
- ☐ Spots
- ☐ Eye inflammation
- ☐ Eye pain
- ☐ Dry or Itchy eyes
- ☐ Other: _____

NOSE
- ☐ Frequent nose bleeds
- ☐ Sinus trouble
- ☐ Allergies or hay fever
- ☐ Frequent colds
- ☐ Other: _____

THROAT/MOUTH
- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Sores in mouth
- ☐ Bad breath
- ☐ Jaw problems
- ☐ Teeth/gum problems
- ☐ Other: _____

SKIN
- ☐ Hives
- ☐ Rashes
- ☐ Eczema
- ☐ Night sweating
- ☐ Excess sweating
- ☐ Dryness
- ☐ Bruise easily
- ☐ Other: _____

RESPIRATORY
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Difficulty breathing
- ☐ Asthma/wheezing
- ☐ Shortness of breath
- ☐ Other: _____

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest pain/tightness
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Other: _____

NEUROLOGICAL
- ☐ Depression
- ☐ Agitation
- ☐ Irritability
- ☐ Nervousness
- ☐ Worry/anxiety
- ☐ Mood swings
- ☐ Memory confusion
- ☐ Suicidal
- ☐ History of psychiatric treatment
- ☐ Seizures
- ☐ Tremors
- ☐ Neuralgia (nerve pain)
- ☐ Numbness/tingling of nerves
- ☐ Pain
- ☐ Paralysis
- ☐ Feeling weak & shaky
- ☐ Other: _____

APPETITE
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Appetite keeps changing
- ☐ Excess thirst
- ☐ Never thirsty
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Nausea/vomiting
- ☐ Indigestion/heartburn
- ☐ Stomach cramps
- ☐ Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting blood
- ☐ Blood in stool/black stools
- ☐ Hemorrhoids
- ☐ Bitter taste in mouth
- ☐ Recent change in weight
- ☐ Other: _____

URINATION
- ☐ Frequent urination
- ☐ Hard to urinate
- ☐ Pain/burning upon urination
- ☐ Blood in urine
- ☐ Weak urinary stream
- ☐ Frequent infections
- ☐ Water retention
- ☐ Edema
- ☐ Incontinence
- ☐ Other: _____

MUSCLE AND JOINT
- ☐ Joint disorder
- ☐ Sore muscles, tendonitis, etc
- ☐ Weak muscles or repetitive use
- ☐ Stiff all over
- ☐ Difficulty walking
- ☐ Back pain
- ☐ Other: _____

FEMALE
- ☐ Frequent vaginal infections
- ☐ Pain/itching of genitalia
- ☐ Genital lesions/discharge
- ☐ Pelvic inflammatory disease
- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Premenstrual syndrome
- ☐ Abnormal bleeding
- ☐ Menopausal symptoms
- ☐ Breast lumps
- ☐ Low sexual drive
- ☐ Other (incl. STD's)_____

MALE
- ☐ Pain/itching of genitalia
- ☐ Genital lesions/discharge
- ☐ Impotence
- ☐ Low sexual drive
- ☐ Pain with ejaculation
- ☐ Premature ejaculation
- ☐ Prostrate trouble
- ☐ Lumps in testicles
- ☐ Other (incl. STD's) _____

SLEEP & ENERGY
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Excess dreaming
- ☐ Disturbing dreams
- ☐ Poor energy
- ☐ Other: _____