Patient Name DOB
Age Gender
Appointment Date and Time:_____
Primary Care Provider: _____
****Please attach or bring with you, any test and lab results you have had over the past 6 months.**

Concern (please rank by priority)	Onset	Frequency	Severity
Example: Headache	June '99	4 times/week	Mild/Moderate/Severe

What are your goals for this visit?
_____
_____
_____
_____

What medical conditions do you have or have you had? Example: Diabetes, breast cancer, high blood pressure

What	When	What	When

Have you had any surgical procedures or injuries?

What	When	What	When

Are there specific diseases that run in your immediate family?

Disease	Family Member	Disease	Family Member

Review of Systems
Problems System Describe
No Yes Cardiovascular (chest pain, high blood pressure, fainting)
No Yes Respiratory (shortness of breath, wheezing)
No Yes Metabolic (thyroid disorder, abnormal blood sugars, energy level, always hot or cold)
No Yes Neurological (headaches, numbness, dizziness, weakness)
No Yes Gastrointestinal (irregular bowel habits, cramping, heartburn)
No Yes Skin (rashes, itching, dryness)
No Yes Musculoskeletal (joint pain, muscle pain or spasm)
No Yes Ears, Nose and Throat (hearing, sinus congestion, allergy)
No Yes Vision (blurred, seeing double or spots)
No Yes Difficulty sleeping, Fever, Weight loss/gain
No Yes Mood (anxious, worried, tense, stressed)
No Yes Sexual function (poor desire, trouble having orgasm)

Medication Allergies: _____

Please list any prescription medications and/or supplements, vitamins, herbs you are taking now.

Brand or Generic Name	Reason	Year Started	Dosage Example:
Ex:Siberian ginseng	*Energy*	*2001*	*500mg daily*
-			

_____
_____
_____
_____
_____
_____
_____
_____

Tobacco? Yes No Type & frequency
Alcohol? Yes No Estimated drinks per day
Other drugs? Yes No Type & frequency

Have you ever had a problem with a substance or substances? Yes No

Social History With whom do you live? (Include roommates, friends, partner, spouse, children, parents, relatives, and pets)

Name	Age	Relationship	Name	Age	Relationship
_____	____	_____	_____	_____	____ _____
_____	_____	____	_____	_____	_____
_____	____	_____	_____		

Describe your sleep (duration, quality, etc) _____

What do you do to relax? What interests/hobbies do you have?

_____

_____

_____

_____

_____

In what physical activities do you participate in? Activity Frequency Duration Intensity

_____ _____ _____ _____

_____ _____ _____ _____

What are the 3 major stressors in your life currently and in the past?

Current Past

_____ _____

_____ _____

_____ _____

Do you have a meditation, relaxation, spiritual, reflective, or centering practice that you do?

_____

_____

_____

What complementary and alternative therapies have you experienced or explored?

_____

_____

_____

Do you have any food intolerances or allergies?

_____

Completed by: _____

Date: _____

Reviewed by:_____ Date:_____