Confidential Health Inventory

GENERAL INFORMATION: Date: _____

Name: _____ Age: _____ Birth Date: _____
LAST FIRST MIDDLE

Address:_____ Weight:_____ Height: _____
City _____ State _____ Zip _____
Mailing Address (if different): _____
Email Address: _____
Preferred Phone: _____ (□ Cell □ Home □ Office) FAX: _____
Occupation: _____ Employer: _____
Employment Status: □ Full-time □ Part-time □ School □ Retired □ Unemployed □ Other _____
Relationship Status: □ Living with parent(s) □ Single □ Married □ Divorced □ Widowed
Living Situation: □ Alone □ Friend(s) □ Partner □ Spouse □ Parents □ Caregiver □ Assisted living
Name of Partner/Spouse/Parent: _____ Occupation: _____
Number of children at home: _____ Number of children total: _____ Pets: _____
Educational Background: □ Elementary/Middle □ High School □ Some College □ Bachelors Degree
□ Some Graduate School □ Masters Degree □ PhD □ Specialty (MD, DO, etc)
Who referred you? _____
Primary physician:_____ Phone: _____ Fax:_____
Other practitioners on your team _____ Phone: _____ Fax:_____
_____ Phone: _____ Fax:_____
_____ Phone: _____ Fax:_____

In Case of Emergency Contact: _____ Phone: _____
Relationship to you: _____

FINANCIAL AGREEMENT:
I claim full financial responsibility for services rendered and understand that payment is required in full at the time of service unless special arrangements have been made in advance. I understand that missed appointments are charged at the full fee for the time allotted.

Credit/Debit Card: _____ Exp: _____ CVV: _____

MAIN REASON AND GOALS FOR THIS APPOINTMENT:

_____

_____

DIAGNOSES (if any):_____ Date of Dx(s) _____

By signing you certify that all the above is correct. You agree to pay for services rendered and any scheduled appointments not cancelled 24 in advance. Also by supplying an email address and signing here you agree to receive emails regarding scheduling and the work we do together. Your information is never sold or rented.

Signed: _____ Relationship to client: _____

CURRENT MEDICAL STATUS

In general, I feel my overall health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Supplements: *Use additional paper if necessary*

Name	*Brand*	*Dose*	*Frequency*

Medications: *Use additional paper if necessary*

Medications are you currently taking, including over the counter and prescription:

Drug	*Dose*	*Reason*	*When did you start?*

Drug allergies (penicillin, etc.): _____

Do you use NSAIDs such as aspirin, ibuprofen, Aleve, Naproxen, Motrin? ☐ No ☐ Yes, how often: _____

Acetaminophen (Tylenol)? ☐ No ☐ Yes, how often: _____ Benadryl? ☐ No ☐ Yes, how often: _____

Have you used proton pump inhibitors (Prevacid, Nexium, Priolosec)? ☐ No ☐ Yes, how often: _____

About how many times have you been on **antibiotics** in the last 5 years? _____

Were you treated with antibiotics repeatedly as a child? ☐ No ☐ Yes, please explain:

_____

_____

Surgeries/Hospitalizations: (major or minor with approximate dates): *Use additional paper if necessary*

_____

_____

_____

Dates of General Anesthesia (being "put under" for a procedure): _____

If you've had radiation and/or chemotherapy treatments, please use an additional page and indicate dates, doses, agents used, duration, and describe your experience with the treatment.

Pain ☐ No pain currently; ☐ Yes, and the pain is mostly located: _____

Male (Female - see last page)
___Premature ejaculation ___Impotence ___Infertility ___Low sexual energy ___Enlarged prostate
___Other_____

Energy Levels
___High ___Medium ___Low ___Fluctuates ___Fatigue after meals ___Energized after meals

Emotions
The predominant emotion(s) I experience lately are: ☐ Anger; ☐ Optimism; ☐ Joy; ☐ Worry; ☐ Grief; ☐ Fear;
☐ Depression; ☐ Anxiety; ☐ Irritability; ☐ Other _____
Significant emotional states as a child or in the past:_____
Please mention any major traumas:_____
Other:_____
Do you have a history of depression or anxiety? ☐ No ☐ Yes, please list any medications used _____
_____

Substances
Tobacco use: ☐ Never
☐ Yes, but not any longer: How long? _____ Year quit _____
☐ Yes, currently: How much? _____ How long? _____
☐ I want to quit as soon as possible; ☐ I have no intention of quitting
Alcohol use: Preferred type(s): _____
How much? _____ How often? _____
Caffeine use: ☐ Tea; ☐ Coffee; ☐ Energy Drinks; ☐ Coke/Pepsi/other caffeinated soda _____
I drink my tea/coffee ☐ black, ☐ cream/creamer, ☐ sugar, ☐ NutraSweet/Splenda, ☐ other: _____
How much? _____ How often? _____
Types of sweeteners used: ☐ sugar/cane juice; ☐ honey or maple syrup; ☐ agave; ☐ stevia; ☐ monk fruit;
☐ NutraSweet/aspartame; ☐ Splenda/sucralose; ☐ sugar alcohols (maltitol, xylitol, sorbitol, erythritol)

Mood altering substances (past/present): *this is completely confidential but important for me to know*
Type: _____ How much? _____ How often? _____
Have any of the above substances become a problem in your life? ☐ No ☐ Yes
☐ I want to quit as soon as possible; ☐ I have no intention of quitting

DIET & LIFESTYLE
Dietary preferences/restrictions: _____
☐ Omnivorous ☐ Vegetarian (with some ☐ eggs, ☐ dairy, ☐ fish) ☐ Vegan; since _____
☐ Low-fat ☐ Low-calorie ☐ Paleo ☐ Ketogenic ☐ Zone ☐ Other: _____

Routine physical exercise: ☐ None ☐ Yes, type: _____
How often? _____
Do you feel you have a stressful life? ☐ No ☐ Yes; how long has it been stressful? _____
If so, do you practice any stress reduction techniques? ☐ No ☐ Yes, please list _____
_____
_____

MARK THE FOLLOWING: O IF OCCASIONAL, 1 IF CURRENT, 2 IF MORE THAN 12 MONTHS AGO

___Abnormal Pap smear
___AIDS/HIV
___Alcoholism
___Allergies; type_____
___Anemia; type_____
___Arthritis
___Asthma
___Bleed easily
___Breast Lumps
___Cancer; type _____
___Catch colds easily
___Concussion
___Crohn's disease
___Chronic cough
___Diabetes
___Eating disorder
___Epilepsy
___Fainting/blackouts
___Gallbladder problem
___Glaucoma
___Hair loss
___Headache/Migraine
___Heart attack
___Heart disease
___Hemorrhoids
___Hepatitis
___High blood pressure
___Low blood pressure
___High cholesterol
___High fevers
___IBS/IBD
___Infertility
___Jaundice
___Kidney disease
___Low blood pressure
___Lyme's disease
___Mental disorder
___Mono or EBV
___MS
___Obesity
___Osteopenia/-porosis
___Palpitations
___Pacemaker
___Parasites
___Pneumonia
___Poor memory
___Prostate problems
___SIBO
___Sinus infections
___Skin problems
___Sleep apnea
___use a CPAP
___Stroke
___Thyroid problems
___Ulcers
___Ulcerative colitis
___Varicose/spider veins
___Other_____
___Other_____

Digestion & Stools Bowel Movement Frequency is _____ # of times per day usually at what time of day? _____

___Formed
___Soft/Loose
___Watery
___Diarrhea
___Hard
___Dry
Constipation
___Alternating
___Incomplete/difficult
___Has undigested food
___Contains mucus
___Contains blood
___Odorous
Bloating
___Gas
___Painful digestion
___Food allergies/problems
___Belching
___Nausea
___Vomit
Ulcer
___Poor appetite
___Excessive appetite
___Hemorrhoids
___Rely on supplement for elimination
___Other_____
Other

Urination

Frequency is _____ # of times per day
___Clear
___Pale yellow
___Medium yellow
___Dark yellow
Green
___Orange
___Bloody
___Urgent
___Burning
Dribbling

Night time _____# of times
___Profuse
___Scanty
___Output = input
___Odorous
Cloudy
___Edema/Puffy skin
___Infections
___Stones
___Other_____

Sleep

Hours per night:_____ Time to bed:_____ Time to wake:_____
___Trouble falling asleep
___Trouble staying/going back to sleep
Vivid/disturbing dreams
___Sweating
___Palpitations
Rested when wake up
___Trouble waking up/groggy
___Other_____

Skin/Hair/Nails

___ Acne
___ Psoriasis
___ Eczema
Hives
___ Itchy skin/scalp
___ Dry skin/scalp
___ Oily skin/scalp
Athlete's foot
___ Flaky skin
___ Bruise easily
___ Nail ridges
White spots in nails
___ Brittle hair
___ Hair loss
___ Other:_____

Sensory Organs

___Blurry vision
___Poor P.M. Vision
___Itchy eyes
___Watery eyes
___Floaters
___Dizzy/Vertigo
___Weak hearing
___High pitch ear Ring
___Low pitch ear Ring
___Ear Infections
Ear Discharge
___Sinus infections
___Nasal Congestion/ Post Nasal Drip
___Fillings (#)_____
___Teeth loss
Sensitive teeth
___Bleeding Gums
___Bad Breath
___Other: _____

FAMILY HISTORY

Please include any of the following: alcoholism, high blood pressure, cancer with type, diabetes, heart disease, osteoporosis, depression, other addiction or illness.

☐ I am adopted and don't know my genetic history

☐ I am adopted and this is the health history of my adoptive family

Family Member	**Age if Living**	**Cause of Death/ Age**	**Important Health Issues**
Mother			
Father			
Sibling M/F			
Sibling M/F			
Mom's Mother			
Mom's Father			
Dad's Mother			
Dad's Father			
Mom's Sibling M/F			
Mom's Sibling M/F			
Dad's Sibling M/F			
Dad's Sibling M/F			

GENETICS

☐ I have had some genetic testing done (23andMe, Ancestry.com)

☐ I am interested in discovering more about my genes

☐ I am not interested

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW?

FOR WOMEN ONLY:

MENOPAUSE (if still cycling, please skip to the next section)
No menses since_____
Describe any experiences/symptoms you are feeling/having:

List any hormone replacement therapy you are taking including dose and brand:

MENSTRUAL PERIODS
Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment.

If you know, what was/is your Mother's experience with menopause?

Menstruating since age: _____ Regular: □ No □ Yes

Length of cycle: _____ Flow lasts how many days? _____

□ Light flow □ Heavy Flow Clots: □ No □ Yes Color of blood: □ bright red □ dark red

Date of last menses: _____

Do you experience PMS: □ No □ Yes, describe symptoms:

Menstrual Cramps: □ No □ Yes, which days?_____

Vaginal Discharge: □ No □ Yes Color _____ Frequency_____ Amount_____

Spotting between periods: □ No □ Yes Color: □ bright red □ dark red

MARK THE FOLLOWING: 0 = never 1 = current 2 = past

___ hysterectomy	___ irregular PAP smear	___ tubal ligation
___ fibroids	___ herpes	___ ablation
___ D&C	___ interstitial cystitis	___ irregular bleeding
___ pain with intercourse	___ infertility	___ breast cancer
___ dryness with intercourse	___ endometriosis	___ mastectomy
___ HPV	___ other _____	

DO YOU HAVE BREAST IMPLANTS: □ No □ Yes; If yes, any problems?

PREGNANCY/BIRTH CONTROL
Are you pregnant now □ No □ Yes Are you thinking about getting pregnant soon? □ No □ Yes
Number of pregnancies _____ Number of children _____
Terminations _____ Miscarriages _____ Tubular pregnancies _____
Difficulty in conceiving □ No □ Yes
Birth control method(s):

If you have used hormonal birth control methods, please list which, how old you were, and for how long: