NATURAL glow HEALTH CENTER, PLLC

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General Information

Patient Name: _____Date:_____

Wellness goals – check those that you are interested in:

☐Acupuncture	☐Improved energy	☐Reduce drug side effects
☐Ayurveda	☐Improved fitness	☐Shamanic Healing
☐Chiropractic	☐Improved sleep	☐Stress reduction
☐Eliminate pain	☐Lab tests	☐Supplements for health
☐Emotional well-being	☐Orthotics	☐Supportive cancer care
☐Fertility	☐Prevent chronic disease	☐Therapeutic massage
☐Hormone balancing	☐Primary care	☐Weight loss
☐Improved basic health	☐Psychotherapy	

Current Complaint

Main problem(s) you'd like help with._____
_____
How long ago did this problem begin (month/day /year)?_____
Does this problem interfere with your daily activities (work, sleep, sex)?_____
Problem gets worse with…_____
Problem gets better with…_____
Have you ever been given a diagnosis for this problem?_____
What kinds of treatment have you tried?_____

Past History

Hospitalizations_____
_____
Significant illnesses_____
_____
Significant traumas or injuries_____
_____
Date of last physical exam _____

Please check any condition that applies to you or a family member and include the date(s). (Self=S, Family=F)

	S	F		S	F
Addiction issues	☐	☐	Asthma	☐	☐
Allergies	☐	☐	Gout	☐	☐
Alzheimer's	☐	☐	Cancer	☐	☐
Anemia	☐	☐	What type?_____		
Arthritis	☐	☐			

	S	F		S	F
Depression/ Anxiety	☐	☐	High blood pressure	☐	☐
Diabetes	☐	☐	High cholesterol	☐	☐
Edema	☐	☐	HIV	☐	☐
Eczema	☐	☐	Kidney disease	☐	☐
Epilepsy	☐	☐	Mental illness	☐	☐
Headaches	☐	☐	Osteoporosis	☐	☐
Heart attack/disease	☐	☐	Stroke	☐	☐
Hepatitis	☐	☐	Thyroid disease	☐	☐
Herpes	☐	☐	Tuberculosis	☐	☐

Habits

Alcohol (per week) _____
Coffee/tea/ cola (per week) _____
Soft drinks (per week) _____
Tobacco (packs per day) _____
Drugs (for non medical purposes) _____
Sleep (hours per night) _____
Water (per day) _____

Have you ever been on a restricted diet? Y/ N What kind?_____

Average daily diet:

Morning Afternoon Evening

_____

_____

Do you crave sugar or salty foods? Y/ N Which? _____

Do you have a regular exercise program? Y/ N If yes, please describe:_____

_____

Do you have a spiritual practice? Y/ N If yes, please describe:_____

_____

Do you have allergies? (food, environmental, drug?) If yes, please list:_____

_____

Please list prescription and over the counter medications you are taking.

Medication Dose Date started Prescribed by

_____

_____

_____

_____

Please list vitamins, minerals, herbs, and homeopathic remedies you are taking.

Supplement Dose Date started

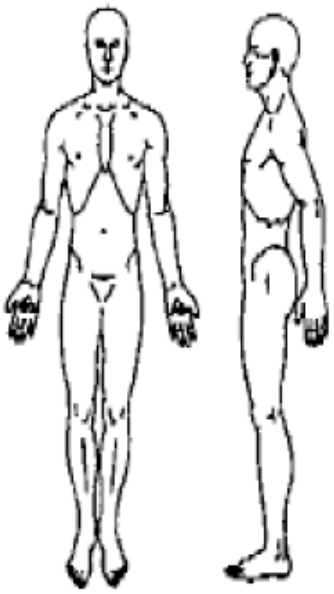
_____

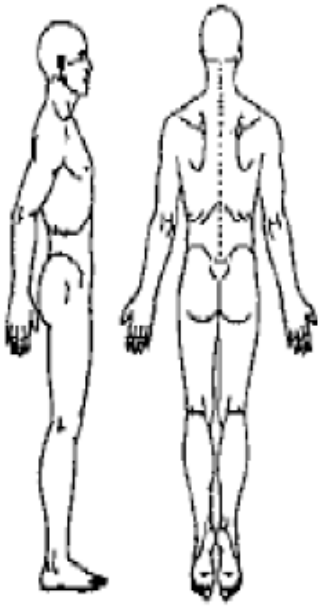
_____

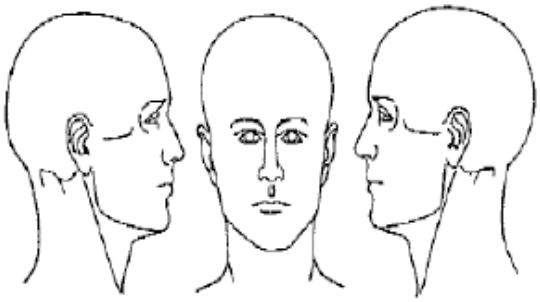
_____

_____

Please indicate painful or distressed areas:
Pain level (please mark with an X): No pain_____Worst possible pain







Notes:

_____

_____

_____

_____

_____

Review of Systems
Please check following: N=condition you have now, P=condition you've had in the past

	N	P
Skin		
Dry	☐	☐
Oily	☐	☐
Itching	☐	☐
Rashes	☐	☐
Hives	☐	☐
Fungal Infection	☐	☐
Bruise easily	☐	☐
Slow healing	☐	☐
Warts	☐	☐
Nails Soft ☐	Break ☐	
Head		
Headaches	☐	☐
Migranes	☐	☐
TMJ/jaw pain	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Tremors/Seizures	☐	☐
Eyes		
Vision disturbance	☐	☐
Dryness	☐	☐
Tearing	☐	☐
Pain	☐	☐
Styes	☐	☐
Sensitive to light	☐	☐

	N	P
Ears		
Discharge	☐	☐
Itch	☐	☐
Pain	☐	☐
Ringing	☐	☐
Poor hearing	☐	☐
Nose		
Allergies	☐	☐
Discharge	☐	☐
Color: Clear__ Yellow __ Green __		
Texture: Thin __ Thick __		
Post Nasal Drip	☐	☐
Stuffiness	☐	☐
Sneezing	☐	☐
Infections	☐	☐
Nosebleeds	☐	☐
Frequent colds	☐	☐
Throat/Neck		
Sore throat	☐	☐
Swollen Glands	☐	☐
Difficulty swallowing	☐	☐

	N	P
Mouth		
Dryness	☐	☐
Canker sores	☐	☐
Bleeding gums	☐	☐
Respiratory		
Pneumonia	☐	☐
Bronchitis	☐	☐
Cough	☐	☐
Asthma	☐	☐
Shortness of breath	☐	☐
Coughing up blood	☐	☐
Cardiovascular		
Chest pain	☐	☐
Heart racing/pounding	☐	☐
Heart Disease	☐	☐
Murmur	☐	☐
Blood Pressure High__ Low __		
Cholesterol High__ Low __		
Leg Pain__ Cramps __		
Ankle swelling	☐	☐
Cold Hands__ Feet __		

Digestion N P

Bowel Movement
X per day:
1-2__2-3__3-4__4+ __

X per week:
1-2__2-3__3-4__4+ __

Texture:
Dry__Hard__Loose __
Formed__ Firm ___

Stools with
Mucus __ Blood __

Hemorrhoids ☐ ☐
Fissures/Fistula ☐ ☐
Stool incontinence ☐ ☐
Liver/
gallbladder disease ☐ ☐
Ulcer ☐ ☐
Heartburn ☐ ☐
Bloating ☐ ☐
Belching ☐ ☐
Gas ☐ ☐
Nausea ☐ ☐
Pain/cramps ☐ ☐

Urinary

Difficult urination ☐ ☐
Painful urination ☐ ☐
Incontinence/dribbling ☐ ☐
Blood in urine ☐ ☐
Cloudy urine ☐ ☐
Frequent urination
Day__ Night__
Bladder infections ☐ ☐

Muscular/Skeletal

Back Pain
Low ☐ Mid ☐ Neck ☐
Pain in muscles ☐ ☐
Pain in joints ☐ ☐
Stiffness/ Swelling ☐ ☐
Muscle weakness ☐ ☐
Numbness/Tingling ☐ ☐
Shooting pain ☐ ☐
Paralysis ☐ ☐
Broken bones ☐ ☐
Which?_____
_____
Sprained joints ☐ ☐
Which?_____
_____
Foot pain ☐ ☐

Energy (Scale of 1-10)
1=worst, 10=best _____

Sleep

How many hours? _____
Wake easily? Y / N
Hard to fall asleep? Y / N
Wake rested? Y / N
Snore? Y / N
Grind teeth Y / N
Dreams? Y / N

Temperature

Sensitive to: hot__cold__
Prefer: inside__ outside__

Perspiration

Sweat easily ☐ ☐
Night sweats ☐ ☐
Appetite: excessive __ good__
poor__
Prefer foods: hot__ cold __
Prefer drinks: hot __ cold__
Thirst: excessive__ none__
Recent weight change:_____

Mental/Emotional

Anxiety ☐ ☐
Stress (scale of 1-10
1=none,10=max) _____
Depression ☐ ☐
Suicidal thoughts ☐ ☐

Men Only

Date of last prostate exam:___
Prostate enlargement ☐ ☐
Change in force of urine
stream? ☐ ☐
Dribbling ☐ ☐
Difficulty starting and
stopping urination? ☐ ☐
Pain in scrotum ☐ ☐
Painful intercourse ☐ ☐
Difficult erections ☐ ☐
Change in sex drive ☐ ☐
STD ☐ ☐
Which?_____
_____
Sexual abuse ☐ ☐
Fertility issues ☐ ☐
Discharge from penis ☐ ☐

Women Only

Date of last pelvic exam:_____
Abnormal pap smear ☐ ☐
STD ☐ ☐
Which?_____
_____
Sexual abuse ☐ ☐
Yeast infections ☐ ☐
Vaginal discharge ☐ ☐
Age of first period _____
Irregular periods ☐ ☐
Flow: heavy__ medium__
light__
Length of cycle _____
Days of flow _____
Date of last period _____
Spotting ☐ ☐
Cramps ☐ ☐
PMS ☐ Endometriosis ☐
Cysts ☐ Fibroids ☐
Have you ever used birth
control pills
How long?_____
When? _____
Present birth control
method?_____
Change in sex drive ☐ ☐
Painful intercourse ☐ ☐
Pregnancies (#) _____
Children (#) _____
Complications ☐ ☐
Miscarriages (#) _____
Abortions (#) _____
Fertility issues ☐ ☐
Hysterectomy ☐ ☐
Age at menopause ☐ ☐
Vaginal dryness ☐ ☐
Hot flashes ☐ ☐
Do you do self breast exams?
Yes No ☐
Date of last mammogram:____