



# wholebody solutions

nutrition • chiropractic • acupuncture • massage • skin care

**Note: Information provided on this form is confidential. Please take a moment to complete the form in detail.**

**Please PRINT**

Today's Date \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Street Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Which should we call to confirm appts? \_\_\_\_\_

Your occupation \_\_\_\_\_ # of hours you work per day \_\_\_\_\_ and week \_\_\_\_\_

Email: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Has your weight fluctuated greatly in the past 3 years? \_\_\_\_\_

Status:  Single  Married  Divorced  Separated  Live with partner

Emergency Contact / Relationship: \_\_\_\_\_ Tel: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

**CURRENT HEALTH**

What are the main symptoms/problems for which you are seeking treatment?

1. \_\_\_\_\_

How long have you had this? \_\_\_\_\_ The on-set was:  Sudden  Gradual

What diagnosis / treatment have you received? \_\_\_\_\_

2. \_\_\_\_\_

How long have you had this? \_\_\_\_\_ The on-set was:  Sudden  Gradual

What diagnosis / treatment have you received? \_\_\_\_\_

Please list any previous surgeries, hospitalizations and serious illnesses with dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list below all of the medications/supplements/herbs you take:**

<u>Medication/Supplement/Herb</u>	<u>Dose</u>	<u>Reason for Taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Diet** Please give a general description of the food you eat during a "typical" day.

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Before bed: \_\_\_\_\_

Between meals: \_\_\_\_\_

### WESTERN MEDICAL DIAGNOSIS

**Please check off any Western Diagnosis you have now or have had in the past:**

- |                                      |   |   |                                       |  |
|--------------------------------------|---|---|---------------------------------------|--|
| <input type="checkbox"/> AIDS/HIV    | <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Joint replacement        | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Multiple sclerosis       | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart attack      |
| <input type="checkbox"/> TB          | <input type="checkbox"/> Depression     | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Epilepsy/seizures |

Cancer: type: \_\_\_\_\_ current status: \_\_\_\_\_

Allergies: what drugs or substances (plant, animal, environmental) \_\_\_\_\_

### What are Your Treatment Goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

### DIAGNOSTIC QUESTIONS

Please indicate which symptoms below you have experienced **within the past 3 months**. **Please circle according to the severity of your symptoms: L=Light M=Medium S=Strong** (Leave blank if you do not have the symptom.)

#### HEAD,

L M S headaches- where are the headaches: Side, Top, Back or Front of head; How often \_\_\_\_\_

L M S sinus infections      L M S grind teeth      L M S dizziness/vertigo

L M S sinus pressure      L M S jaw pain

L M S thrush/leukoplakia      L M S migraines

#### EYES, EARS, NOSE, THROAT

L M S runny nose      L M S nasal congestion      L M S nose bleeds

L M S vision problems      L M S floaters in eyes      L M S dry/itchy eyes

L M S ringing in ears      L M S difficulty hearing      L M S ear aches

L M S bleeding gums      L M S sores in mouth      L M S dry mouth      L M S thirst

L M S difficulty swallowing      L M S sore throat      L M S other: \_\_\_\_\_

**SKIN/HAIR/NAILS**

L M S itchy/painful rashes      L M S fungus      L M S cold sores      L M S spider veins  
 L M S psoriasis/eczema      L M S shingles      L M S acne      L M S dry skin  
 L M S bleed/bruise easily      L M S hair loss      L M S mole changes      L M S other: \_\_\_\_\_

**RESPIRATORY**

L M S shortness of breath      L M S phlegm      L M S pain w/deep breath      L M S bronchitis  
 L M S coughing up blood      L M S wheezing      L M S chronic cough      L M S tightness in chest  
 L M S asthma      L M S other \_\_\_\_\_

**CARDIOVASCULAR**

L M S low blood pressure      L M S chest pain      L M S high cholesterol  
 L M S high blood pressure      L M S palpitations      L M S other: \_\_\_\_\_

**GASTROINTESTINAL**

L M S loss of appetite      L M S weight loss      L M S abdominal pain      L M S insatiable hunger  
 L M S vomiting      L M S gas/bloating      L M S belching      L M S burning sensation  
 L M S heartburn      L M S ulcers      L M S other: \_\_\_\_\_

**STOOLS**

L M S diarrhea      L M S loose stools      L M S constipation      L M S blood in stool  
 L M S mucus in stool      L M S urgency      L M S cramping with BM      L M S hemorrhoids

**GENITALS / URINARY**

L M S frequent urination      L M S night urination      L M S impotence      L M S incontinence  
 L M S painful urination      L M S kidney stones      L M S low sex drive      L M S dribble if sneeze or cough  
 L M S urinary track infections      L M S blood in urine      L M S genital warts/sores      L M S other: \_\_\_\_\_

Average color of urine (ignore first urination of day): pale      medium yellow      dark yellow

**MUSCULAR / SKELETAL / NEUROLOGICAL**

L M S muscle/joint pain      L M S back pain      L M S stiff neck/shoulder      L M S weakness  
 L M S tremors      L M S seizures      L M S leg cramps      L M S restless leg  
 L M S tingling, numbness or pain in arms, fingers, legs or toes (neuropathy)      L M S other \_\_\_\_\_

**SLEEP**

L M S trouble falling asleep      L M S trouble staying asleep      L M S disturbing dreams  
 L M S trouble falling back asleep      L M S restless sleep      L M S wake feeling unrested

**PSYCHOLOGICAL / EMOTIONAL**

L M S irritability/anger      L M S depression      L M S disorientation      L M S substance abuse  
 L M S forgetfulness      L M S anxiety      L M S worry      L M S bipolar  
 L M S poor concentration      L M S schizophrenia      L M S other \_\_\_\_\_

**WHOLE BODY SYMPTOMS**

L M S swollen lymph nodes      L M S night sweats      L M S fatigue      L M S frequent colds  
 L M S glucose intolerance      L M S day sweats      L M S chills      L M S other \_\_\_\_\_

**GYNECOLOGICAL/OBSTETRICS**

L M S yeast infections      L M S clots      L M S mid-cycle pain      L M S vaginal pain/itching  
L M S pelvic infections      L M S no periods      L M S PMS      L M S vaginal discharge  
L M S menstrual cramps      L M S spotting      L M S irregular periods      L M S Other \_\_\_\_\_  
L M S hot flashes      L M S night sweats      L M S fibroids

Menstrual Info: age of first period \_\_\_\_\_ days of bleeding \_\_\_\_\_ days of cycle \_\_\_\_\_ date of last period \_\_\_\_\_

Do you take Hormone Replacement Therapy?     Yes     No

Are you pregnant?     Yes       No     Unknown    Are you presently trying to get pregnant?     Yes     No

(Please alert your practitioner if you become pregnant. Your treatment will be modified to support a healthy pregnancy).

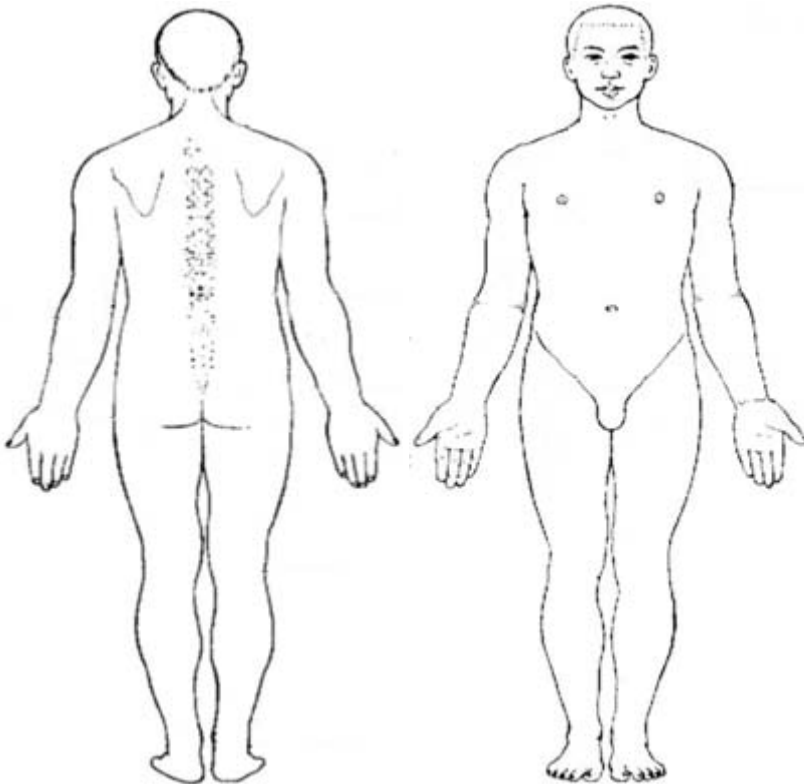
Are you in menopause?     Yes       No       Unknown

How many pregnancies have you had? \_\_\_\_\_ # of births \_\_\_\_\_ # of Cesareans \_\_\_\_\_ # of children \_\_\_\_\_

Date last pap smear \_\_\_\_\_      NORMAL      ABNORMAL

Last breast exam \_\_\_\_\_      NORMAL      ABNORMAL

**Indicate Painful or Distressed Areas**



**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_