

NAME _____ DATE _____

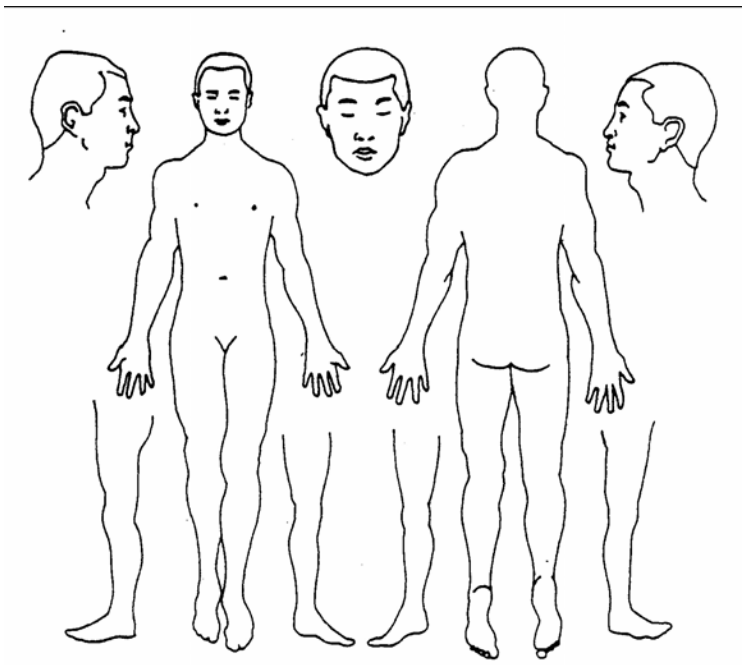
I. Goals: What would you most like to achieve through your work at the TLC Integrative Health?

1. _____
2. _____
3. _____
4. _____
5. _____

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

1. _____
2. _____
3. _____
4. _____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

- X X X Sharp/stabbing
- P P P Pins & Needles
- D D D Dull/Aching
- N N N Numbness

For Women:

1. Are you pregnant now? [] Yes [] No [] Unsure
2. Indicate number of occurrences:
Live Births _____ Pregnancies _____ Miscarriages _____ Abortions _____
3. Age: First period _____ Menopause (if applicable) _____
4. Date: Last Pap Smear _____ / _____ Last Mammogram _____ / _____
5. Any History of an Abnormal Pap Smear? [] Yes [] No If so, what / when? _____

6. Is your menses cycle regular? Yes No
 a) Average number of days of flow _____
 b) The flow is: Normal Heavy Light
 c) The color is: Normal Dark Purple Light Brown Brown

7. Do you have the following menstruation related signs/symptoms?

- Difficulty with Orgasm Cramps PMS Heavy Vaginal discharge between periods
 Pain with Intercourse Nausea Bleeding between Periods
 Blood Clots Breast Distention Vaginal Discharge

For Men:

1. Do you have any bothersome urinary symptoms? Yes No

Describe: _____

2. Check all that apply:

- Erectile dysfunction Difficulty with orgasm Pain or swelling of the testicles Frequent need to urinate at night
 Impotence/erectile dysfunction Premature ejaculation Feeling of coldness or numbness in genitalia
 Pain/Subtly of testicles

3. Do you get up at night to urinate? Yes No How often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

5. Have you sought Medical intervention for these problems? If so, when? _____

6. What treatments have you tried for these problems and how successful have they been?

III. Medical History

<i>Please check all that apply</i>	<i>Date Diagnosed</i>		<i>Date Diagnosed</i>
Diabetes	___/___/___	High Cholesterol	___/___/___
High Blood Pressure	___/___/___	High Blood Pressure	___/___/___
Thyroid Disease	___/___/___	Seizures	___/___/___
Cancer	___/___/___	Hepatitis	___/___/___
HIV	___/___/___	Others	___/___/___

IV. Surgical History

Date _____
 Date _____
 Date _____

V. Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (to medications, chemicals or foods):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VIII. Nutrition

1. Do you follow a special diet? [] Yes [] No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)

2. What do you eat on a "typical" day? _____

- a) Breakfast _____
- b) Lunch _____
- c) Dinner _____
- d) Snacks _____
- e) Foods you tend to crave: _____
- f) Foods you dislike: _____

IX. Social History

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: _____

b) Alcohol: _____

c) Cigarettes, cigars, other tobacco: _____

d) Other drugs: _____

2. Have you ever had a problem with *alcohol* or *alcoholism*? [] Yes [] No

3. Have you ever had a problem with *dependency* on other drugs? [] Yes [] No

4. If yes which and when?

5. Do you have a known history of any exposure to *toxic* substances? [] Yes [] No

6. If so, please list which and when you first noticed symptoms?

7. In the past year, how many days have been significantly affected by your health? _____

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen:

Hours per week: _____ Activities: _____ [] No Exercise

11. How many hours of sleep do you usually get per night during the week? _____

12. Do you awake feeling rested? [] Yes [] No Do you feel you sleep well at night? [] Yes [] No

13. Who would you describe as your source of primary social support? (relationship to you)

X. Other Information

Please list and briefly describe the most significant events in your life:

1. _____

2. _____

3. _____

4. _____

Have you been treated for emotional issues? [] Yes [] No

Have you ever considered or attempted suicide? [] Yes [] No

Do you have any other neurological or psychological problem? [] Yes [] No

Please provide us with any other information that you think is relevant for us to know:

HEALTH: CHECK ALL THAT APPLY

GENERAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Poor appetite
[]	[]	Excessive appetite
[]	[]	Insomnia
[]	[]	Fatigue
[]	[]	Fevers
[]	[]	Night sweats
[]	[]	Sweat easily
[]	[]	Chills
[]	[]	Localized weakness
[]	[]	Poor coordination
[]	[]	Bleed or bruise easily
[]	[]	Catch cold easily
[]	[]	Change in appetite
[]	[]	Strong thirst
[]	[]	Other: _____

SKIN & HAIR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Rashes
[]	[]	Hives
[]	[]	Itching
[]	[]	Eczema
[]	[]	Pimples
[]	[]	Dryness
[]	[]	Tumors, lumps

HECK & NECK

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Dizziness
[]	[]	Fainting
[]	[]	Neck stiffness
[]	[]	Enlarged lymph glands
[]	[]	Headaches
[]	[]	Concussions
[]	[]	Other: _____

EARS

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Infection
[]	[]	Ringing
[]	[]	Decreased hearing
[]	[]	Other: _____

EYES

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Blurred vision
[]	[]	Visual changes
[]	[]	Poor night vision
[]	[]	Spots
[]	[]	Cataracts
[]	[]	Glasses / contacts
[]	[]	Eye inflammation
[]	[]	Other: _____

NOSE, THROAT, MOUTH

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Nose bleeds
[]	[]	Sinus infections
[]	[]	Hay fever or allergies
[]	[]	Recurring sore throats
[]	[]	Grinding teeth
[]	[]	Difficulty swallowing

CARDIOVASCULAR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	High blood pressure
[]	[]	Low blood pressure
[]	[]	Blood clots
[]	[]	Palpitations
[]	[]	Phlebitis
[]	[]	Chest pain
[]	[]	Irregular heart beat
[]	[]	Cold hands / feet
[]	[]	Fainting
[]	[]	Difficult breathing
[]	[]	Swelling of hands / feet
[]	[]	Other: _____

RESPIRATORY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Asthma
[]	[]	Bronchitis
[]	[]	Frequent colds
[]	[]	Chronic obstructive
[]	[]	Pulmonary disease
[]	[]	Pneumonia
[]	[]	Cough
[]	[]	Coughing blood
[]	[]	Production of phlegm
[]	[]	Other: _____

GASTRO-INTESTINAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Nausea
[]	[]	Vomiting
[]	[]	Diarrhea
[]	[]	Belching
[]	[]	Blood in stools/black
[]	[]	Stools
[]	[]	Bad breath
[]	[]	Rectal pain
[]	[]	Hemorrhoids
[]	[]	Constipation
[]	[]	Pain or cramps
[]	[]	Indigestion
[]	[]	Gall bladder disorder
[]	[]	Gas
[]	[]	Other: _____

GENITO-URINARY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Kidney stones
[]	[]	Pain or urination
[]	[]	Frequent urination
[]	[]	Blood in urine
[]	[]	Urgency to urinate
[]	[]	Unable to hold urine
[]	[]	Other: _____

MALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Pain / itching genitalia
[]	[]	Genital lesions/ discharge
[]	[]	Impotence
[]	[]	Weak urinary stream
[]	[]	Lumps in testicles
[]	[]	Other: _____

FEMALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Frequent urinary tract infections
[]	[]	Frequent vaginal infections
[]	[]	Pain / itching of genitalia
[]	[]	Genital lesions / discharge
[]	[]	Pelvic inflammatory disease
[]	[]	Abnormal pap smear
[]	[]	Irregular menstrual periods
[]	[]	Painful menstrual periods
[]	[]	Premenstrual syndrome
[]	[]	Abnormal bleeding
[]	[]	Menopausal syndrome
[]	[]	Breast lumps
[]	[]	Hot flashes
[]	[]	Menopausal syndrome
[]	[]	Other: _____

NEUROLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Seizures
[]	[]	Tremors
[]	[]	Numbness/tingling of limbs
[]	[]	Concussion
[]	[]	Pain
[]	[]	Paralysis
[]	[]	Other: _____

PSYCHOLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Depression
[]	[]	Anxiety / stress
[]	[]	Irritability
[]	[]	Treated for emotional or
[]	[]	Psychological problems
[]	[]	Other: _____

INFECTION SCREENING

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	HIV
[]	[]	TB
[]	[]	Hepatitis
[]	[]	Gonorrhea
[]	[]	Chlamydia
[]	[]	Syphilis
[]	[]	Genital warts
[]	[]	Herpes: oral
[]	[]	Herpes: genital

MUSCULAR-SKELETAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[]	[]	Stiff neck / shoulders
[]	[]	Low back pain
[]	[]	Back pain
[]	[]	Muscle spasm, twitching, cramps
[]	[]	Sore, cold or weak knees
[]	[]	Joint pain