Clinic Evaluation Form

Date ___/___/_____

Name _____ **Age** ____ **Sex** **M** □ **F** □ **Status** **S** □ **M** □ **D** □ **W** □

Address _____ **City State** _____ **Zip Code** _____

D.O.B ___/___/___ **Occupation** _____ **Tel. # Day** ( ) _____ **Evening** ( ) _____

Referred By: _____ **Private Physician** _____

Email:_____

Last Check Up _____ **Private Physician Phone #** ( ) _____

State your present complaint, injury or illness

What's your main complaint?_____

_____

When did it begin?_____ **Describe what causes it?**_____

What makes it better?_____ **What makes it worse?**_____

Is your condition getting worse? □ **Yes** □ **No**

Does it interfere with: □ **Work** □ **Sleep** □ **Daily Routine** **Other Explain:**_____

What medical diagnosis have you received? _____

What medication are you taking?_____

For what condtions?_____

Secondary Complaints:_____

Previous Medical Care:_____

Please indicate all surgeries, type and year_____

Have you ever been advised to have surgery which was not done?_____

Have you ever been hospitalized for anything other than surgery?_____

Personal Medical History

Have you had any of these? Please check all that apply.

□ **AIDS/HIV**	□ **Cancer**	□ **Herpes**	□ **Polio**	□ **Latex Allergy**
□ **Alcoholism**	□ **Diabetes**	□ **Hypertension**	□ **Rheumatic Fever**	□ **Lymph Nodes**
□ **Allergies**	□ **Emphysema**	□ **Lyme Disease**	□ **Scarlet Fever**	**removed**
□ **Asthma**	□ **Heart Disease**	□ **Multiple Sclerosis**	□ **Seizures**	□ **Drug Problem**
□ **Birth Trauma**	□ **Hepatitis A/B/C**	□ **Pacemaker**	□ **Tuberculosis**	□ **Syphilis**
(your own birth)	□ **Anemia**	□ **Gallbladder disease**	□ **Kidney Disease**	□ **Meningitis**

Are you currently preganat? □ Yes □ No **Are you presently trying to get pregnant?** □ Yes □ No

Family Medical History

□ Cancer □ Stroke □ Hypertension □ Diabetes □ Scoliosis □ Kidney Disease □ Glaucoma

□TB □ Epilepsy □ Headache □ Ulcers □ Asthma □ Allergies □ Arthritis □ Mental Disorder

□ Alcoholism □ Drug Problem

Other: _____

Diet and Food

How is your appetite?_____

Any food cravings?_____

List any food intolerances_____

Are you always thirsty? □ Yes □ No Do you prefer Hot □ or Cold drinks □

Gastrointestinal

I have (Check all that apply) □ Blenching □ Nausea □ Vomiting □ Ulcers □ Bloating □ Acid □ Regurgitation

□ Hernia □ Heartburn □ Indigestion □ Severe Stomach Pain □ Other _____

Bowel Movement How often?_____Day/Week Painful Bowel movement □ Yes □ No

I have (Check all that Apply) □ Irregular □ Constipation □ Diarrhea □ Gas □ Burning □ Hemorrhoids

□ Use Laxatives □ Undigested food in stool □ Loose stool □ Hard Stool □ Blood in stool □ Itchiness □ Other_____

Emotion & Sleep

How do you feel emotionally?_____

Do you have (check all that apply) □ Panic Attacks □ Depression □ Anxiety □ Bad Temper □ Nervousness

□ Fear attacks □ Poor memory □ Difficult concentration □ Other_____

□ Married/Stable Relationship □ Single How do you feel about your relationship?_____

How do you hold stress?_____

How do you relax?_____

How do you feel about your work?_____

How long do you normally sleep?_____hours per night

I have difficulty with (check all that apply) □ Falling asleep □ Staying asleep □ Disturb Sleep

Waking up about_____am/pm and no being able to fall asleep again because_____

Women

At what age did you start menstruating?_____ Number of days between cycles?_____

Number of days of flow_____ Color_____

I have or have had (check all that apply) □ Irregular menstruation □ Heavy flow □ Light flow □ No flow

□ Clots □ Vaginal itching/burning □ Spotting between periods □ Discomfort/pain before period

□ Discomfort/pain during period □ Other_____

Any vaginal discharge? □ Yes □ No Amount_____ Color_____ Frequency_____

PMS Symptoms_____

Number of pregnancies?_____ Number of delivers?_____ Abortion(s)/Miscarriages(s)?_____

Menopausal Symptoms_____

Men

I have (check all that apply) □ Prostatitis □ Impotence □ Penis blood/mucous discharge □ Other_____

Urinary &Genital

Urination How often?_____times per day Color □ Pale yellow □ Dark yellow/orange

I have or have had (Check all that apply) □ Trouble starting stream □ Frequent urination □ Incontinence

□ Pain □ Trouble holding urine □ Burning □ Dribbling when sneezing □ Urinary tract infections

□ Blood in urine □ Kidney stones □ Other_____

How is your sexual energy?_____

What kind of birth control do you use?_____

Do you have (check all that apply) □ Infertility □ Pain during sexual relations □ Other_____

Muscle, Joint & Bones

Do you have pain or tightness? Where?_____

The pain is (Check all that apply) □ Sharp □ Aching □ Numb □ Deep pain □ Burning □ Dull Pain

□ Superficial Pain □ Tingling □ Pain Worse/Better with heat □ Pain Worse/Better with Pressure

□ Pain Worse AM/PM
I have (Check all that apply) □ Swollen joints □ Arthritis/joint pain □ Tendentious □ Rheumatism
□ Bone pain □ Muscle cramping □ Muscle Pain □ Respective strain injury □ Other_____

Respiratory, Eyes, Ears, Nose, Throat & Head

Do you smoke? □ Yes □ No _____per day, for_____years

I have (Check all that apply) □ Frequent colds □ Chronic runny nose □ Chronic Couch □ Coughing blood

□ Pain Inhaling □ Shortness of breath on exertion/ at rest □ Asthma □ Nose bleeds □ Pain/ red eyes

□ Poor vision □ See spots □ Dizziness □ Cold sores □ Bleeding gums □ Dry mouth □ Frequent sore throat

□ Ear pain □ Ringing in ears □ Clogged/popping ears

Cardiovascular

Blood Pressure_____/_____Have you ever been diagnosed with heart trouble? □ Yes □ No

I have (Check all that apply) □ Chest pain □ Palpation □ Varicose veins □ Phlebitis □ Cold hands & feet

□ Irregular heart beat □ Poor circulation □ Other_____

Skin & Hair

I have or often have (check ALL that apply) □ Dry skin □ Skin rashes □ Itching □ Acne □ Eczema □ Hives

□ Hair loss □ Premature graying □ Other _____

On the following drawing SHADE the area that u feel should be addressed.