Family Medical History (General Health):

Mother's Side:_____

Father's Side:_____

Siblings:_____

If above deceased, cause of death:_____

Childhood Health: (Physical)_____(Emotional)_____

Location of upbringing:_____

Current Emotional Health:_____

Current predominant emotion:_____

Current Quality of Life:_____

Current Relationship/Quality:_____

Is there much stress in your life?_____What?_____

Hobbies and recreational Habits:_____

Favorite time of year:_____Worst time of year:_____

Do you have a regular exercise program?_____Please describe:_____

_____

Travel abroad within the past year? Where?_____

Do you feel you have a good appetite?_____Good eating habits?_____

Please describe your average daily diet:

Morning Afternoon Evening

_____

_____

_____

Proportion of raw food_____to cooked food_____

Do you get any cravings?_____What/When?_____

Prefered Tastes: Sour_____ Bitter_____ Sweet_____ Spicy_____ Salty_____

How many packs of cigarettes do you smoke a day?_____

How much coffee, tea or cola do you drink per week?_____

How much alcohol do you drink per week?_____

Please describe any recreational drug use: (This information is strictly confidential)_____

_____

Have you ever abstained from or "quit" anything?_____

Do you have any nervous habits?_____

What factors in your life seem most important to your daily health?_____

_____

What factors in your life seem most destructive to your daily health?_____

_____

Please check if you now have, or if you have ever had, any of the following:

____Cancer	____Arthritis	____Hepatitis	____High Blood Pressure
____Diabetes	____Asthma	____HIV/AIDS	____Thyroid Disorders
____Stroke	____Allergies	____Herpes	____Rheumatic Fever
____Heart Disease	____Seizures	____Tuberculosis	____Addictive Disorders
____Heart Attack	____Parasites	____Weight Disorders	____Mental Illness

Please explain:_____

Please check if you have experienced within the past three months:
Mark one check if occassionally, two checks if frequent, and three checks if it is a constant problem.

General:
___Fevers
___Chills
___Fatigue
___Poor Sleep/Insomnia
___Dream Disturbed Sleep
___Depression
___Mania
___Emotional Changes
___Tremors
___Seizures
___Night Sweats
___Day Sweating
___Poor Balance
___Weight Loss
___Weight Gain
___Poor Appetite
___Change in Appetite
___Peculiar tastes or smells
___Sudden energy drops
What time of day?_____
___Strong thirst, for hot or cold drinks?_____
___Headaches
___Localized Weakness
___Bleeding or Bruising
___Joint Pain

Cardiovascular:
___High Blood pressure
___Low Blood Pressure
___Irregular Heartbeat
___Chest Pain / Angina
___Dizziness
___Fainting
___Cold Sweats
___Swelling of Feet
___Swelling of Hands
___Difficulty in Breathing
___Cold Hands or Feet
___Phlebitis
___Blood Clots
___Palpitations

Respiratory:
___Cough
___Asthma
___Bronchitis
___Pain with Deep Breaths
___Difficulty in Breathing When Laying Down
___Easily Winded with Exertion
___Shortness of Breath
___Coughing of Blood
___Production of Phlegm
What Color?_____

Gastrointestinal:
___Nausea
___Vomiting
___Indigestion
___Ulcers
___Abdominal Pain or Cramps
___Digestive Disorders
___Belching
___Bad Breath
___Gas
___Constipation
___Diarrhea
___Blood in Stools
___Hemorroids
___Hernia

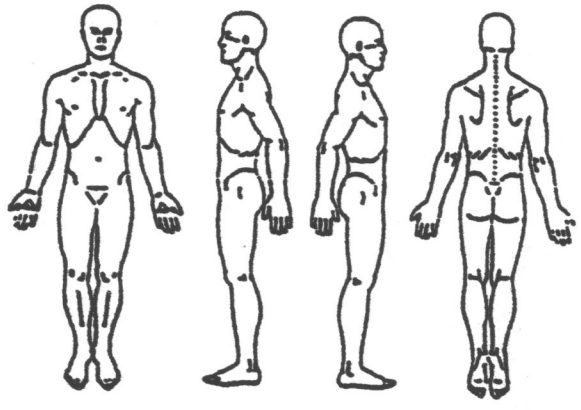
Genito-urinary:
___Pain on Urination
___Urgent Urination
___Frequent Urination
___Unable to Hold Urine
___Decrease in Urine
___Blood in Urine
___Impotency/Infertility
___Genital Sores
___Kidney Stones
___Waking Up to Urinate
How Often?_____

Musculoskeletal:
___General aches
___Muscular Atrophy
___ Muscular Weakness
___Arthritis
___Joint Instability
___Muscle Cramps
___Spasms
___Recent Sprains
___Injuries or Falls

Please Circle on the diagram any areas of any type of pain or injury.

Please try and describe the type and quality of the pain.

_____



Ear, Nose & Throat:

____Ringing in Ears
_____Poor Hearing
____ Earaches
_____Ear Discharge
____Sinus Problems
____Nose Bleeds
____Recurrent Sore Throat
____Sores on Lips or Tounge
____Thirst w/o desire to drink
____Teeth Problems
____Grinding Teeth
____Gum Problems
____Facial Pain
____Jaw Clicks

Eyes & Vision:

_____Glasses
____ Poor Vision
_____Blurred Vision
____Eye Strain
____Cataracts
____Glaucoma
____Eye Pain
____Eye Dryness
____Eye Redness
____Color Blindness
____Night Blindness
____Floaters in Vision
____Spots in Front of Eyes
____Eye Itchiness

Skin and Hair:

____Rashes
_____Itching
____Eczema
____Ulcerations
____Hives
____Pimples
____Recent Moles
____Dandruff
____Loss of Hair
____Any Change in Hair or Skin Texture

Neuropsychological:

____Siezures
____Concussion
____Dizziness
____Headaches
____Migraines
____Areas of Numbness
____Lack of Coordination
____Loss of Balance
____Fainting
____Disorientation
____Irritability
____Easily Susceptible to Stress
____Easily Angered
____Depression
____Mania
____Anxiety
____Poor Memory

Have you ever been treated for emotional, neurological or psychological problems?
Please explain_____

Pregnancy and Gynecology:

_____Age at first Menses
_____Days between Menses
_____Duration of Menses
_____First Date of Last Menses
_____Heavy or _____Light
_____Irregular Periods
_____Painful Periods
_____Number of Pregnancies
_____Number of Births
_____Miscarriages
_____Abortions
_____Difficult Births
_____Premature Births
_____Breast Lumps
_____Clots
Birth Control?_____
What Type?_____
How Long?_____
Currently?_____
_____Fertility Problems
_____Vaginal Discharge
_____Vaginal Sores
_____Last PAP Smear

Do you experience changes in Body &/or Psyche prior to menstruation?_____

Are there any other problems, conditions or observations that you would like to discuss?_____

_____

_____

What are your goals for your health & life?_____

_____

_____