STATE OF HEALTH HISTORY

Name_____ Address ---------- _____

Cell Phone | Work Phone | Marital Status S M D W

Date _____

DOB Age _____ Weight now/1 yr ago__/_____ Occupation _____ No. of Children _____

Email _____ Referred by /How did you hear about us? _____

_____ _____

REASON FOR CARE (Circle all that apply and write brief description) Wellness/ proactive care Imbalances_____

Chronic condition _____ __

Other_____

STRESSORS - Stresses from daily living you are, or have been, exposed to.

Check P (Past) and/or C (Current) where	P	C	Comments	LIST Top PERSONAL STRESSORS IN LIFE
Large Physical (Accidents, falls, sports, trauma, surgery, electric shock, fighting, difficult birth)				1.
Constant Physical (Repetitive Motion, poor posture, limp, sit/stand all day, computer work, carry child/heavy bag)				2.
Large Chemical: (Toxic Exposure, Serious Infections, hormonal changes, transplant)				3.
Constant Chemical: (Medication, allergens, new home, pollution, pesticides, implants)				4.
Large Mental/Emotional (Recent move/change in life, New Relationship/ Newly Married, death of relation, sense of danger, financial difficulty, separation from loved one, serious illness)				5.
Constant Mental/Emotional (Deadlines/ overworked, in a hurry, lack of sleep, negative attitude, skipped meals, abused/manipulated, sustained concentration, relationship issues, uncertain about future)				LIST Top HEALTH ISSUES / GOALS 1. 2. 3. 4. 5.

HABITS THAT EITHER CREATE EASE OR MORE STRESS IN YOUR BODY: Mark an "XU on the line indicating if you are closer to adding stress to your body or relieving stress for each habit.

Ease	Stress
Drink >5 glasses of water/day	Drink coffee / sodas/ alcohol
Eat whole foods (fruits, veg, grain, meats),olive oil/ butter, balanced diet	Eat refined/processed foods (crackers, sweets, canned),fried foods/ hydrolyzed fat, same foods a lot
Exercise / Walk up stairs	Exercise Regularly
Stretch	No active stretching - inflexible
Wear supportive shoes	Wear shoes with little support or heels
Feel rested / sleep on side on good bed / use cervical pillow	Un-rested/sleep on backor on stomach bad bed / unsupportive pillow
Do what you enjoy	Do what you have to
Take breaks throughout day	Work continuously through day
Quality time w/ family /friends	Work all the time
Positive mental attitude / find purpose in life	Negative thoughts / aimless purpose
Ask yourself difficult questions	Avoid internal/external conflict
Laugh at self	Take yourself seriously

SYMPTOMS - Check if you are experiencing currently (C) or have experienced in the past (P).

Symptom	P	C	Symptom	P	C	Symptom	P	C	Symptom	P	C
t.Frequent infections			25.Seizures			49.Food sensitivities			73.Joint stiffness		
2.Allerqies			26.0ther brain issues			50.Rash/itchinq			74.Joint swellinq/pain		
3.Fatique			27.Difficulty chewinq/TMJ			51.Anemia			75.Bumps around ioints		
4.Dizziness			28.Mind "races"			52. Hepatitis			76.Shin splints		
5.Meningitis			29.Difficulty balancing			53.Jaundice			77. Groin pulls		
6.Diabetes			30.Numbness/tingling			54.Gall Bladder			78.Disc problems		
7.Thyroid			31.Muscle stiffness/pain			55.Nausea/vomitinq			79.Sciatica		
8.Adrenal			32.Muscle weakness			56.Abdominal pain			80.Stenosis		
9.Hormones			33.Difficulty breathinq			57.Liver issues			81.Hip/Knee problems		
10.Eye/visual problems			34.Persistent Couch			58.Inflammation of bowel			82.Pain in ball of foot		
11.Difficulty hearing			35.wheezinq/asthma			59. Constipation			83.0ther foot problems		
12.Ringing in ears			36.Pulmonary issues			60.Change in bowel habits			84.Shoulder/Arm/Hand		
13.Nose bleeds			37.Shortness of breath			61.Hernia			85.Low back Pain		
14.Difficulty smellinq			38.Chest discomfort			62.Change in appetite			86.Ribcage		
15.Sinus irritation			39.Ankle swellinq			63.FreQuent urination			87.Tendonitis		
16Hoarseness/ Difficulty swallowinq			40.Sudden calf pain			64.Urinary urgency/ hesitancy/pain			88.Suppressed Immune System		
17.Anxious or Depressed			41.Hiqh blood pressure			65.Flank/side pain			88.Arthritis of spine		
18.Easily irritated/ difficulty focusinq			42.0ther heart issues			66.Endometriosis/ breech/frontal birth			89.Tumor / Growth		
19.Difficulty relaxing			43.Stroke			67.Pelvic pain			90.Mole chances		
20.Insomnia			44.Blood clots			68.Yeast infections			91.weight loss		
21.Get UP during night			45. Heartburn/reflux			69.Enlarqed prostate			92.Cancer		
22.Irritated by bright light			46.Indiqestion			70.In Reproductive system			93.Chanqe in nails or skin		
23.Neck stiff or painful			47.Ulcer			71.Auto immune condition			94.Loss of flexibility		
24.Headaches			48.Distentionl"gassy"			72.Strep infections			95.Loss of strenqth		

Women		Men	
Date of last menstrual period		Prostate condition?	
Regular or Irregular periods? Flow?		Diminished urinary flow?	
Are you pregnant or trying to get pregnant?		Other	

List accidents, falls, fractures, sprains, strains **List hospitalizations/ surgeries** **List** medications/supplements

Family History of Disease: _____

Personal History of Disease or Chronic Condition: _____

Anything else you would like to add?

Dr.'s Notes