Specialty Natural Medicine INC PC

Health Form

Date: _____

Last Name:_____ First Name: _____

Birth date: _____ Gender: _____ Age: _____

Present Health Concerns

Please list health concerns in their order of significance	What was the name of the past diagnosis of this problem?
1.	
2.	
3.	
4.	
5.	

Please list prescription medications that you are currently taking, with dose:

1. _____ 2. _____

3. _____ 4. _____

List vitamins, minerals, herbs, or any other non-prescription medications that you are currently talking, with dose:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please list any severe or life-threatening allergies: _____

Personal Habits

Please check any of the following substances that you use daily: ◯ Tobacco ◯ Coffee/Black Tea/Cola ◯ Alcohol ◯ Recreational Drugs

Do you exercise regularly? ◯ No ◯ Yes What Type of exercise? _____

How long each time? _____ How often per week? _____

Do you sleep through the night? ◯ Yes ◯ No How many hours on average do you sleep nightly? _____

Would you consider yourself under excessive stress? _____ Are you willing to make changes? _____

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Past Medical History

Hospitalizations for: _____ Dates: _____

Serious Illnesses/ Injuries: _____

Date of last annual physical/gynecological exam: _____ Date of last blood tests: _____

Personal & Family History

Please check the "yes" box next to each condition that applies to you or one of your family members. Write the type of relation or write self in the "relation" box.

	YES	RELATION		YES	RELATION
Alcoholism/Drug Addiction			Headaches		
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Asthma			Kidney Disease		
Cancer			Mental Illness		
Depression			Stroke		
Diabetes			Tuberculosis		
Eczema			Other		
Epilepsy			Other		

Social History

Please check those that apply: ⬭ Single ⬭ Married ⬭ Partner/Significant Other

Do you have any children? ⬭ Yes ⬭ No Age(s)/Name(s): _____

Review of Systems

Please check any of the following that apply to you

Fatigue		Excessive Thirst		Unusual weight gain or loss	
Unusual nighttime perspiration		Rashes or Itching		Sores that do not heal	
Unusually dry skin		Unusual new skin growths		Blurred vision	
Glaucoma		Eye pain		Recent changes in vision	
Trouble hearing		Ringing in the ears		Congestion	
Post nasal drip		Earaches		Frequent nosebleeds	
Persistent hoarseness		Sore tongue or mouth		Bleeding gums	
Frequent colds or flu		Constant cough		Coughing up blood	
Difficulty breathing		Chest pain		Ankle swelling	
Irregular heartbeat		Muscle cramps		Cold hands or feet	
Frequent Urinary infections		Burning urination or unusual discharge		Involuntary urination (with coughing)	
Blood in urine		Prostate trouble (men only)		Back pain	
Joint swelling or stiffness		Frequent or severe headaches		Frequent fainting or lightheadedness	
Double vision		Difficulty with memory		Convulsions or seizures	
Numbness or tingling in arms or legs		Nervousness		Unusual fevers	

Women Only answer question or answer yes or no

Age of start of menstrual cycle		Are your cycles consistent number days		Average number of days between bleeds	
Average number of days of bleed		Do you bleed/spot between cycles		Are bleeds excessively heavy/with clots	
Do you have unusual pain with bleed		Do you use contraception?		Type of contraception:	
Hot flashes or night sweats		Past menopause		Age at menopause	
Bleeding after menopause		Nipple discharge			

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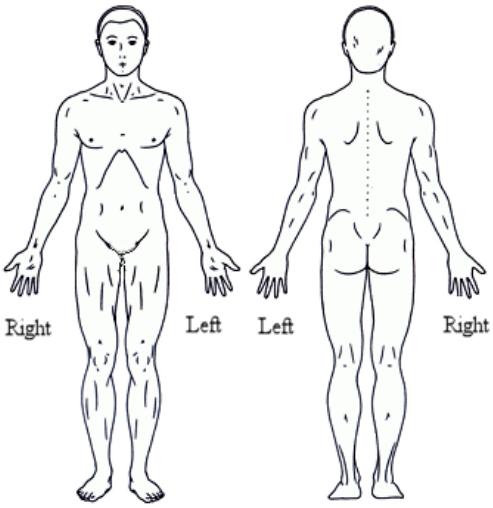
Chiropractic, Acupuncture and Biopuncture

(Does not need to be completed except for Chiropractic and Pain Management Appointments)



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day? Y/N

Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____

Reason for seeking care: _____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
List the names of any relatives that have or have had a similar problem: _____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____

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