Today's Date: _____ **LIFEstrength Health Center** Record #: _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ Secondary Phone: _____

Email: _____ Marital Status: ❑ Single ❑ Married SS #: _____

Job Title: _____ Nature of Business: _____

Spouse's Name: _____ Spouse's Employer: _____

Names of children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Referred by: _____

## HISTORY of COMPLAINT

What do you hope to achieve with us? _____

_____

What are the top 4 health concerns you would like to focus on?

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

On a scale of **0 - 10** with **10** being highest priority and **zero** being least priority, please rate your above complaints by ***circling the number*:**

**Primary** or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Second** complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Third** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Fourth** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What makes you feel better? _____

What makes you feel worse? _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

**Is your problem the result of ANY type of accident? ☐ Yes ☐ No How did the injury happen? _____**

_____

Identify any related **injury(s), minor or major,** that the doctor should know about: _____

_____

***PLEASE MARK / DRAW** the areas on the diagram with the following **letters and** describe the feeling / sensations as best you can:

**R = R**adiating / Throbbing _____

**B = B**urning _____

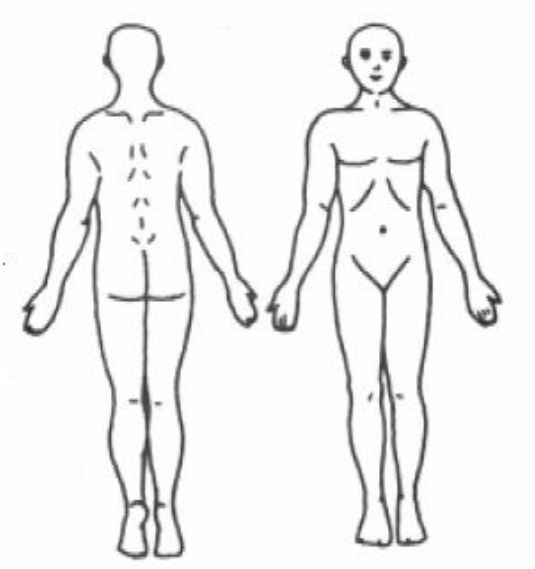
**D = D**ull _____

**A = A**ching _____

**N = N**umbness _____

**S = S**harp / **S**tabbing _____

**T= T**ingling _____



## PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes,** how many times? _____

When / How did the last episode occur? _____

**What you have tried in the past?**

| Prior Treatment / Approach | Name of Physician / Specialist | Effectiveness (0 – 10) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**The next section will prove an in-depth look at your overall health from your start in life. Please list and explain each section. Examples include dislocations, broken bones, cancer, tumors, cysts, disabilities, diabetes, heart attacks, surgeries, jobs with a physical / chemical stress, schools / house with mold, mental / emotional / spiritual stress like a death or divorce or bankruptcy, etc. Please be specific;**

## PATIENT BIRTH HISTORY

❑ Term ❑ Premature ❑ Vaginal Delivery ❑ C-Section Delivery ❑ Formula-fed ❑ Breast-fed How Long? _____

Complications during Pregnancy / Birth? _____

## CHILDHOOD HISTORY

Age of Introduction of Solid Foods: _____ Dairy: _____ Wheat: _____ Nuts: _____ Formula: _____

Did you eat a lot of candy or sugar as a child? _____

Did you have frequent ear infections, strept throat? _____

Age of your first course of antibiotics and number of courses before age 2? _____

As a baby, did you experience any stomach, sleep, or emotional issues? _____

Did you acquire chicken pox naturally? When? _____

As a child, were you up to date with immunizations? _____

Do you feel that immunizations have had an impact on your health? _____

**If relevant, attach an immunization record including types and dates and any reactions.**

## ALLERGIC REACTION HISTORY

| Medication / Supplement / Food | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## GRADE SCHOOL HISTORY

Did you develop any food or seasonal allergies? _____

Did you have any serious infections or experience any traumas? _____

Did you have any anger or attention issues? _____

Other health issues? _____

_____

## HIGH SCHOOL HISTORY

Did you have acne that required medications? What kind? _____

Did you have mono? _____

Other health issues? _____

## COLLEGE HISTORY

Other health issues? Antibiotics, Chemical Exposures, Hospitalizations, Trauma, Stress? _____

_____

_____

## ADULTHOOD HISTORY

Other health issues? Antibiotics, Chemical Exposure, Hospitalizations, Trauma, Stress? _____

_____

How many times have you been on antibiotics in your lifetime? _____

## TRAVEL HISTORY

Foreign Travel? Where? _____

Wilderness Camping? Where? _____

## PERSONAL MEDICAL HISTORY

**If applicable, check appropriate box and provide date of onset/diagnosis:**

### GASTROINTESTINAL

- ❑ Irritable Bowel Syndrome: _____
- ❑ Inflammatory Bowel Disease: _____
- ❑ Crohn's: _____
- ❑ Ulcerative Colitis: _____
- ❑ Gastritis or Peptic Ulcer Disease: _____
- ❑ GERD (reflux): _____
- ❑ Celiac Disease: _____
- ❑ Other: _____

### CARDIOVASCULAR

- ❑ Heart Attack: _____
- ❑ Other Heart Disease: _____
- ❑ Stroke: _____
- ❑ Elevated Cholesterol: _____
- ❑ Other: _____
- ❑ Hypertension: _____
- ❑ Rheumatic Fever: _____
- ❑ Mitral Valve Prolapse: _____
- ❑ Thrombosis: _____
- ❑ None: _____

### METABOLIC / ENDOCRINE

- ❑ Type 1 / 2 Diabetes: _____
- ❑ Weight Gain/Loss: _____
- ❑ Metabolic Syndrome: _____
- ❑ Eating Disorder: _____
- ❑ Endocrine Disorder: _____
- ❑ Polycystic Ovarian Syndrome: _____
- ❑ Pre - Diabetes: _____
- ❑ Hypoglycemia: _____
- ❑ Frequent Weight Fluctuations: _____
- ❑ Hyper/Hypothyroidism: _____
- ❑ Infertility: _____
- ❑ Other: _____

### INFLAMMATORY / AUTOIMMUNE

- ❑ Chronic Fatigue Syndrome: _____
- ❑ Immune Dysfunction: _____
- ❑ Autoimmune: _____
- ❑ Immune Deficiency Disease: _____
- ❑ Shingles / Herpes: _____
- ❑ Other: _____

### CANCER

- ❑ Cancer and Type: _____

### GENITAL / URINARY

- ❑ Kidney Stones: _____
- ❑ Erectile / Sexual Dysfunction: _____
- ❑ Frequent Yeast Infections: _____
- ❑ Gout: _____
- ❑ Frequent Urinary Tract Infections: _____
- ❑ Other: _____

### MUSCULOSKELETAL / PAIN

- ❑ Fibromyalgia: _____
- ❑ Osteoarthritis: _____
- ❑ Car Accidents: _____
- ❑ Stenosis/Spondylolisthesis: _____
- ❑ Spinal Fusion: _____
- ❑ Chronic Pain: _____
- ❑ Other: _____
- ❑ Scoliosis: _____
- ❑ Degenerative Discs: _____
- ❑ Other: _____

### RESPIRATORY

- ❑ Asthma: _____
- ❑ Chronic Sinusitis: _____
- ❑ Bronchitis: _____
- ❑ Emphysema: _____
- ❑ Pneumonia: _____
- ❑ Tuberculosis: _____
- ❑ Sleep Apnea: _____
- ❑ Other: _____

## SKIN

- ❑ Eczema: _____
- ❑ Psoriasis: _____
- ❑ Acne: _____
- ❑ Other: _____

## NEUROLOGICAL / MOOD

- ❑ Depression: _____
- ❑ Anxiety: _____
- ❑ Bipolar Disorder: _____
- ❑ Headaches/Migraines: _____
- ❑ Alzheimer's: _____
- ❑ Other: _____
- ❑ ADD / ADHD: _____
- ❑ Autism: _____
- ❑ Parkinson's: _____
- ❑ Seizures: _____
- ❑ Epilepsy: _____
- ❑ None: _____

## DENTAL

- ❑ Silver Mercury Fillings and Number: _____
- ❑ Root Canals and Number: _____
- ❑ Tooth Pain: _____
- ❑ Gingivitis: _____
- ❑Problems Chewing / TMJ: _____
- ❑ Gold Fillings: _____
- ❑ Implants: _____
- ❑ Bleeding Gums: _____
- ❑ Do You Floss Regularly: _____
- ❑ Other: _____

## WOMEN'S / OBSTETRIC ONLY

- ❑ Age of First Menstruation: _____
- ❑ Days of Cycle: _____
- ❑ Last Menstruation Date: _____
- ❑ Contraceptive Patch and Length: _____
- ❑ Other Contraceptive Use: _____
- ❑ Previous Pregnancy Number: _____
- ❑ Vaginal Deliveries: _____
- ❑ Abortion: _____
- ❑ Post-Partum Depression: _____
- ❑ Frequency of Cycle: _____
- ❑ Has Your Cycle Skipped and How Long: _____
- ❑ Birth Control Pills and Length: _____
- ❑ Nuva Ring and Length: _____
- ❑ Currently Pregnant and Due Date: _____
- ❑ Miscarriages: _____
- ❑ C-Section Deliveries: _____
- ❑ Number of Living Children: _____
- ❑ Gestational Diabetes: _____
- ❑ Breast-Feeding History: _____

## MENOPAUSAL WOMEN ONLY

- ❑ Hot Flashes: _____
- ❑ Disinterest in Sex: _____
- ❑ Facial Hair Growth: _____
- ❑ Vaginal Discharge/Dryness: _____
- ❑ Mental Fogginess: _____
- ❑ Uterine Bleeding: _____
- ❑ Painful Intercourse: _____
- ❑ Acne: _____
- ❑ Other: _____
- ❑ Hormone Replacement Therapy and Length: _____

## MEN'S ONLY

- ❑ PSA Exam and Result: _____
- ❑ Impotence: _____
- ❑ Difficulty Obtaining / Maintaining Erection: _____
- ❑ Urgency/Hesitancy/Change in Urinary Stream: _____
- ❑ Decrease in Physical Stamina / Strength: _____
- ❑ Prostate Enlargement / Infection / Surgery: _____
- ❑ Libido Level Rated 0-10: _____
- ❑ Urination at Night and Number: _____
- ❑ Loss of Urinary Control: _____
- ❑ Other: _____

## PREVENTIVE TESTS AND DATE OF LAST TEST

- ❑ Full Physical Exam: _____
- ❑ Bone Density: _____
- ❑ Colonoscopy: _____
- ❑ Cardiac Stress Test: _____
- ❑ EKG: _____
- ❑ Hemoccult (blood in stool): _____
- ❑ MRI / CT / X-rays: _____
- ❑ Upper Endoscopy: _____
- ❑ Ultrasound: _____
- ❑ Mammogram/Thermal Scan: _____

## SURGERIES

- ❑ Appendectomy: _____
- ❑ Hysterectomy +/- Ovaries: _____
- ❑ Gall Bladder: _____
- ❑ Hernia: _____
- ❑ Tonsillectomy: _____
- ❑ Dental: _____
- ❑ Metal Joint Replacement/Implant (Knee / Hip): _____
- ❑ Heart / Bypass Surgery: _____
- ❑ Angioplasty or Stent: _____
- ❑ Pacemaker: _____
- ❑ GI Surgery: _____
- ❑ C-Section: _____
- ❑ Other: _____
- ❑ None: _____

## BLOOD TYPE

❑ A ❑ B ❑ AB ❑ O ❑ Rh+ ❑ Unknown

## HOSPITALIZATIONS

| Date | Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## CURRENT MEDICATIONS

| Medication | Dose | Frequency | Start Date (MM/YY) | Reason For Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Pharmacy Name: _____ Phone: _____

Address: _____

## PREVIOUS MEDICATIONS – Last 10 Years

| Medication | Dose | Frequency | Start Date (MM/YY) | Reason For Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## CURRENT NUTRITIONAL SUPPLEMENTATIONS – Vitamins, Minerals, Herbs, Homeopathy

| Supplement and Brand | Dose | Frequency | Start Date (MM/YY) | Reason For Use |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## NUTRITIONAL HISTORY

What is your current height and weight? _____ What is your usual weight range (+/- 5 lbs.)? _____

What is your desired weight? _____ What is your highest and lowest adult weight? _____

Have you ever had a nutritional consultation? Why? _____

Which special diet or nutritional program do you currently follow?

❑ None ❑ Low Fat ❑ Low Carb ❑ High Protein ❑Low Sodium ❑ Diabetic ❑ Dairy-Free

❑ 100% Gluten-Free ❑ Gluten-Limited ❑ Vegetarian ❑ Vegan ❑ Paleo ❑ Other: _____

Why do you follow this diet? _____

How willing are you to change your diet rated 0 to 10, 0 being not at all and 10 being extremely ready and willing? _____

How often do you weight yourself? _____

Do you avoid any particular foods? Why? _____

How many meals are you eating on average each day? _____ Do you eat a full breakfast each day? _____

Are you eating snacks between meals? What? _____

Do you grocery shop? If not, who does? _____ Do you read food labels? _____

Do you cook? In not, who does? _____ How many meals do you eat out per week? _____

How many ounces of water do you consume daily? _____ How many alcoholic beverages do you consume daily? _____

How many caffeinated beverages do you consume daily? _____ What kinds (soda, coffee)? _____

Do you feel dependent on them? If so, explain: _____

Do you add sweeteners to your food/beverages? Type? _____

Do you buy organic or conventional fruits and veggies? _____ Organic animal products? _____

How many servings of fruit are you getting daily? _____ Serving of veggies daily? _____

List the three worst foods you eat during an average week: _____

List the three healthiest foods you eat during an average week: _____

How often do you crave salt or sweets? How often? _____ Do you eat a lot after dinner? _____

Are you irritable if meals are missed? _____ How often are meals missed during an average week? _____

Do you feel you digest your food well? _____ Difficulty digesting anything in particular? _____

Do you feel bloated after meals? _____ Excessive gas after meals? _____

Do you experience reflux? _____ From what types of foods? _____

Do you use antacids? Which brand? _____ Do you get relief from them? How long? _____

Excessive belching or burping? _____ Do you have offensive breath? _____

Abdominal pain after meals? _____ Constipation / Diarrhea? _____

How many bowel movements on a daily basis? _____ How many days between bowel movements? _____

Do you have fatigue after meals? Which ones? _____

The most important thing I should change about my diet to improve my health is: _____

_____

## PHYSICAL / FITNESS HISTORY

What is your current exercise program?

| Activity | Number of Sessions/Week | Duration |
|---|---|---|
| | | |
| | | |
| | | |

How willing are you to change your exercise routine, rated 0 to 10, 0 being not at all and 10 being extremely ready and willing? _____

List problems that limit physical activity: _____

Are you happy with your current level of physical ability? _____ How long has exercise been a part of your life?_____

The most important thing I should change about my exercise routine to improve my health is: _____

_____

## SOCIAL HISTORY

Are you currently smoking? _____ How many years? _____ Packs per day? _____

How many attempts to quit? _____ What worked or didn't work? _____

Did you previously smoke? _____ How many years? _____ Packs per day? _____

Are you currently using any recreational drugs? Type: _____

Have you ever used IV or inhaled recreational drugs? Type: _____

## PSYCHOSOCIAL / FAMILIAL HISTORY

Are you happy? _____ Do you feel like your life has meaning and purpose? _____

Do you like the work you do? _____ Have you sought counseling? _____

Are you currently in therapy? What type? _____

Do you feel you have excessive stress in your life? _____ Do you handle it well? _____

Do you have a safe outlet for fun? What? _____

**Number your daily stressors, rated 0 to 10, 0 being not at all and 10 being the worst and most damaging:**

| Work | Family | Social | Finances | Health | Others |
|---|---|---|---|---|---|
| | | | | | |

Do you practice meditation, prayer, or other relaxation techniques? Type and frequency: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Gay/Lesbian ❑ Long Term Partner ❑ Widow

Are you nervous, emotional, anxious, uptight, crabby or short-fused? _____

Do you have resources for emotional support? Type: _____

The most important thing I should change about my stress/coping/emotional routine to improve my health is: _____

_____

## SLEEP HISTORY

Do you feel well rested? Why or why not? _____

Average number of hours you sleep per night: _____ Do you have trouble sleeping? _____

Can't get to sleep? _____ How long does it take to fall asleep? _____Can't stay asleep?_____

What time do you go to bed? _____ What time do you wake up? _____ Do you use sleeping aids? _____

Slow starter in the morning? _____ Afternoon fatigue? When? _____ What helps? _____

Sleep apnea? Mask? _____ Night sweats? When? _____

## ENVIRONMENTAL / TOXICITY HISTORY

Have you ever had any major exposure to a known toxic substance? _____

Do you smell odors when others can't? Which? _____

Do you have a sudden onset of symptoms (headache, skin rashes, nauseas, etc) when exposed to perfume/cologne, cleaning supplies, mold, dust or other allergens? Explain: _____

_____

Please list all known chemical allergies / sensitivities: _____

_____

Are you exposed to new construction (paint, carpet, flooring, etc.) in your current and/or past residence? _____

_____

Are you exposed to new construction (paint, carpet, flooring, etc.) in your current and/or past occupation? _____

_____

Have you worked at/ near any industry that regularly emitted waste into the air/water (golf course, dry cleaner, plant, farm, shipyard, mine, chemical factory, landfill)? _____

_____

Have you ever lived in or worked in a place with mold? When? _____

Are pesticides/herbicides/fertilizer used at your home? _____ Do you live by an airport or highway? _____

Do you wear dry cleaned clothing? _____ Do you have any pets? Type? _____

Do you use candles in your house? _____ Do you use air fresheners in your house/car? _____

Do you heat food in a microwave? _____ How many hours on a cell phone daily? _____

Do you use WiFi in your house? _____ Do you live near a cell phone tower? _____

Do you get regular hair coloring, permanents or acrylic fingernails in a beauty shop? How often? _____

Do you use fabric softeners, scented soaps, detergents, perfumes, cleaning supplies? _____

Has your home ever been treated for fleas, tics or bed bugs? When? _____

Have you ever worked with chemicals related to a hobby (paints, solvents, stains, etc)? _____

Please list any other relevant information including but not limited to metal or plastic pipes, paint, pets, asbestos, power lines, gasoline storage, smoke, construction, mold, unrepaired water leaks, etc. _____

_____

_____

_____

## READINESS ASSESSMENT

**In order to improve your health, with 10 being the highest, how willing are you to;**

| | |
|---|---|
| Significantly modify your diet? | 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| Take several nutritional supplements each day? | 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| Keep a record of everything you eat certain days? | 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| Modify your lifestyle (work demands, sleep habits, exercise routine)? | 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| Practice a relaxation technique? | 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| Engage in communication with this office? | 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |

Comments: _____

How confident are you of your ability to organize and follow through on the above health related activities, rated 0 – 10? _____

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

_____

At the present time, how supportive do you think the people in your life will be to your implementing the above changes? _____

_____

## MEDICAL TEAM

| Doctor's Name | Specialty | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Activities of Daily Living/Symptoms/Medications

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| | | | | |
|---|---|---|---|---|
| Bending | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Concentrating | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Doing computer Work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Gardening | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Playing Sports | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Recreation Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Shoveling | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sleeping | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Watching TV | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Carrying | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dancing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Lifting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Pushing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Rolling Over | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Working | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Climbing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Doing Chores | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Performing Sexual Activity | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Reading | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Running | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting to Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |