PATIENT HISTORY

Date

Your Last Name

Your First Name

Patient Number
(Office Use Only)

1. Review of Systems:

	Below Average	Average	Above Average
a. **Musculoskeletal System** – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	O	O	O
b. **Neurological System** – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	O	O	O
c. **Cardiovascular System** – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	O	O	O
d. **Respiratory System** – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	O	O	O
e. **Digestive System** – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	O	O	O
f. **Sensory System** – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	O	O	O
g. **Skin System** – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	O	O	O
h. **Endocrine System** – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	O	O	O
i. **Genitourinary System** – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	O	O	O
j. **Constitutional System** – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	O	O	O

2. Social History (Tell your doctor about your health habits and stress levels.)

Alcohol use	O Daily	O Weekly	How much?_____
Coffee use	O Daily	O Weekly	How much?_____
Tobacco use	O Daily	O Weekly	How much?_____
Exercising	O Daily	O Weekly	How much?_____
Pain Relievers	O Daily	O Weekly	How much?_____
Soft Drinks	O Daily	O Weekly	How much?_____
Water Intake	O Daily	O Weekly	How much?_____

Hobbies: _____

Prayer or meditation?	O Yes	O No
Job pressure/stress?	O Yes	O No
Financial peace?	O Yes	O No
Vaccinated?	O Yes	O No
Mercury fillings?	O Yes	O No
Recreational drugs?	O Yes	O No

3. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Rising our of chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O
Lying down	O	O	O	O
Bending over	O	O	O	O
Climbing stairs	O	O	O	O
Using a computer	O	O	O	O
Getting in/out of car	O	O	O	O
Driving a car	O	O	O	O
Looking over shoulder	O	O	O	O
Caring for family	O	O	O	O

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	O	O	O	O
Household chores	O	O	O	O
Lifting objects	O	O	O	O
Reaching overhead	O	O	O	O
Showering or bathing	O	O	O	O
Dressing myself	O	O	O	O
Love life	O	O	O	O
Getting to sleep	O	O	O	O
Staying asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O
Yard Work	O	O	O	O

4. Top 5 goals you would like to see achieved through care:

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

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