

# PATIENT HISTORY

Date \_\_\_\_\_

\_\_\_\_\_  
Your Last Name

\_\_\_\_\_  
Your First Name

\_\_\_\_\_  
Patient Number

(Office Use Only)

## 1. Review of Systems:

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

Below Average	Average	Above Average
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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## 2. Social History (Tell your doctor about your health habits and stress levels.)

- Alcohol use       Daily    Weekly    How much? \_\_\_\_\_
- Coffee use        Daily    Weekly    How much? \_\_\_\_\_
- Tobacco use      Daily    Weekly    How much? \_\_\_\_\_
- Exercising        Daily    Weekly    How much? \_\_\_\_\_
- Pain Relievers    Daily    Weekly    How much? \_\_\_\_\_
- Soft Drinks       Daily    Weekly    How much? \_\_\_\_\_
- Water Intake      Daily    Weekly    How much? \_\_\_\_\_

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

Hobbies: \_\_\_\_\_

## 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		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery Shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_