



### Outline Procedures for New Patients

Step One	All new patients are requested to fill out a personal health questionnaire prior to their appointment.
Step Two	Your consultation with the doctor to discuss your health problems.
Step Three	Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if chiropractic neurology care is appropriate for your condition.
Step Four	You will be advised if there is the need for any additional procedures such as X-rays, MRI, or Cat Scan.
Step Five	If your case requires immediate attention, treatment will be administered.
Step Six	You will be scheduled for your "report of findings" to hear your examination results and whether or not your case has been accepted. You will be informed of specific recommendations regarding your condition.

#### Confidential Patient Information

Name		Date	
Street Address		City/State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone/Pager ( )	
Email Address	Date of Birth	Current Age	
Social Security #		Method of Payment	

#### Insurance Information:

Name or Insurance Company	Billing Address	Policy # and Subscriber
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#### Referred by:

Name:	Event (i.e., lecture, etc.):	Other (please specify):
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#### Your Doctors:

Primary Care Physician:	OB/GYN:	Other (please specify):
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**Work Status:**     Employed     Retired     Disabled     Full-time Student     Part-time Student

Employer	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

**Marital Status:**     Married     Single     Divorced     Widow    Spouse's Name \_\_\_\_\_

Why Chiropractic Neurology? Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved to avoid future relapses (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional wellbeing (Comprehensive Care). Chiropractic Neurology offers some of the latest advanced procedures for optimizing your nervous system function.

The Darien Center for Integrative Medicine stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice, and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief Care     Corrective Care     Would like to discuss options with the doctor

**PAYMENT POLICIES**

I understand that Darien Center for Integrative Medicine (DCIM) does not participate in any health-insurance plans. DCIM will file claims with my insurance company. However, those claims will be processed on an out-of-network basis. Therefore, I agree to the following:

1. If my health insurance covers all services rendered by this office, I agree that I am responsible to pay the co-payment for each visit, as well as any portion of my annual out-of-network deductible which applies to my treatment here; or
2. If my health insurance denies coverage for any service rendered by this office, a financial arrangement will be created for me to cover the cost of such treatment. I also agree to pay co-payments and deductible, as described above.
3. If I have no health insurance, a financial arrangement will be created to cover the cost of my treatment here.

In accordance with your office policy, I agree to keep my account up to date, with a balance not to exceed \$50.00.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**FEMALES ONLY**

I, \_\_\_\_\_, To the best of my knowledge confirm that I am not pregnant and waive all responsibility to the Doctor.

**Signature:**

**Date:**

**CONSENT OF TREATMENT OF A MINOR**

I hereby authorize Dr. Robert Zembroski D.C., and whomever he may so designate as his assistant, to administer chiropractic care as he deems necessary to my son/daughter, \_\_\_\_\_, dated at Darien, CT this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**Signature:**

**Witnessed:**

**IN CASE OF EMERGENCY**

Name of relative or close friend not living in your home:

Home Phone

Work Phone

Cell Phone

**Please list your major complaints in order of severity:**

1.	2.
3.	4.
5.	6.

**Complaint #1**

When did you first notice this condition:

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Did it begin:  Immediate or  Gradually? Briefly describe

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What is the exact location of your symptoms:

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Do your symptoms Spread?  No  Yes Where?

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How often do you experience these symptoms?  Constant  Frequent (75% of day)  Often (50%)  
 Seldom (25%)  Rarely (less than 25%)

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Is this condition progressively:  Worsening  Improving or  Unchanged

---

What is the intensity of your symptoms?  Severe  Moderate  Mild

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Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)  
 1  2  3  4  5  6  7  8  9  10

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Is your pain  Deep or  Superficial

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Please indicate the character of your pain:  Dull  Sharp  Burning  Aching  Knife-like  Throbbing

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Are you experiencing any of the following associated symptoms?  Pins/Needles  Tingling  Numbness  Twitching  
 If Yes, Please describe:

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Please indicate what activities provoke (P) or Aggravate (A) your condition:  
 Sitting \_\_\_ min.  Standing  Walking  Lying  Pushing  Pulling  Lifting \_\_\_ lbs.  Gripping  Hot/Cold  
 Coughing/sneezing  Bowel Movements  Mental Activities  Bright lights  Other \_\_\_\_\_  
 Other \_\_\_\_\_  Other \_\_\_\_\_  Other \_\_\_\_\_

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Please indicate what helps to alleviate the pain.  
 Lying  Sitting  Walking  Standing  Rest  Heat/Cold  Medications \_\_\_\_\_  
 \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

Please list what doctors you have seen for this condition. (Please include doctor's name and location, diagnoses, treatment received, and any changes in your condition.


Please include any other relevant history in regards to this complaint.


**Complaint #2**

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like <input type="checkbox"/> Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: <input type="checkbox"/> Sitting ___min. <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Pushing <input type="checkbox"/> Pulling <input type="checkbox"/> Lifting ___ lbs. <input type="checkbox"/> Gripping <input type="checkbox"/> Hot/Cold <input type="checkbox"/> Coughing/sneezing <input type="checkbox"/> Bowel Movements <input type="checkbox"/> Mental Activities <input type="checkbox"/> Bright lights <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include doctor's name and location, diagnoses, treatment received, and any changes in your condition.


Please include any other relevant history in regards to this complaint.


**Complaint #3**

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/>
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like <input type="checkbox"/> Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: <input type="checkbox"/> Sitting ___min. <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Pushing <input type="checkbox"/> Pulling <input type="checkbox"/> Lifting ___ lbs. <input type="checkbox"/> Gripping <input type="checkbox"/> Hot/Cold <input type="checkbox"/> Coughing/sneezing <input type="checkbox"/> Bowel Movements <input type="checkbox"/> Mental Activities <input type="checkbox"/> Bright lights <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include doctor's name and location, diagnoses, treatment received, and any changes in your condition.


Please include any other relevant history in regards to this complaint.


**Past Medical History**

Please include any of your previous conditions.

If possible include: Dates, Diagnosis, Treatment received and any Residuals you still suffer from.

***Utero, Birth and Infancy***

Was your mother healthy when you were in utero? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Did she smoke or consume alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Where were you born?
Were you delivered <input type="checkbox"/> vaginally or through <input type="checkbox"/> cesarean section?
Were there any complications during your birth process? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Were you vaccinated? <input type="checkbox"/> No <input type="checkbox"/> Yes
Did you have normal neurological, structural, emotional, and social development? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

Did you have any of the following:

Injuries, Accidents, Falls or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

***Childhood (ages 2 – 12)***

Did you have normal neurological, structural, emotional, social, and academic development? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain

Please rate the following abilities and traits:

Academics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Athletics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Injuries, Accidents, Falls or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

***Teens (ages 13-19)***

Did you have normal neurological, structural, emotional, social, and academic development? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain

Please rate the following abilities and traits:

Academics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Athletics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Injuries, Accidents, Falls or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

Females Only: What age did you start your menses? \_\_\_\_\_  Regular  Irregular

**Twenties**

Academics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Athletics	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Motor Vehicle Accidents  No  Yes ExplainWork Injuries  No  Yes ExplainIllnesses/Hospitalizations:  No  Yes ExplainInjuries, Accidents, Falls, or Traumas  No  Yes ExplainSurgeries:  No  Yes Explain**Thirties**

Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Motor Vehicle Accidents  No  Yes ExplainWork Injuries  No  Yes ExplainIllnesses/Hospitalizations:  No  Yes ExplainInjuries, Accidents, Falls, or Traumas  No  Yes ExplainSurgeries:  No  Yes Explain**Forties**

Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Motor Vehicle Accidents  No  Yes ExplainWork Injuries  No  Yes ExplainIllnesses/Hospitalizations:  No  Yes ExplainInjuries, Accidents, Falls, or Traumas  No  Yes ExplainSurgeries:  No  Yes ExplainFemales Only (40's): Menopausal Symptoms  None  Yes Explain

***Fifties***

Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Motor Vehicle Accidents <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Work Injuries <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Injuries, Accidents, Falls, or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Females Only (50's): Menopausal Symptoms <input type="checkbox"/> None <input type="checkbox"/> Yes Explain

***Sixties***

Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Motor Vehicle Accidents <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Work Injuries <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Injuries, Accidents, Falls, or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

***Seventies***

Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Emotional	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Did you have any of the following:

Motor Vehicle Accidents <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Work Injuries <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Illnesses/Hospitalizations: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Injuries, Accidents, Falls, or Traumas <input type="checkbox"/> No <input type="checkbox"/> Yes Explain
Surgeries: <input type="checkbox"/> No <input type="checkbox"/> Yes Explain

**Family History**

Mother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Father <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Brother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Brother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Sister <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Sister <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Children: Ages and health conditions? _____
Maternal Grandmother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Maternal Grandfather <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Paternal Grandmother <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____
Paternal Grandfather <input type="checkbox"/> Alive & Well, age ____ <input type="checkbox"/> Deceased age ____ From what? _____ Any Healthy Conditions? _____

Have any of your family members ever suffered from any of the following conditions?

<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Neurological Disorders _____
<input type="checkbox"/> Autoimmune Disorders _____ <input type="checkbox"/> Cancer _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

**Medications** Please list your current medications and what they are taken for.


**Vitamins and Minerals** Please list your current supplements and by whom prescribed.


**Habits**

Cigarettes	<input type="checkbox"/> None <input type="checkbox"/> Yes How much per week?
Cigars	<input type="checkbox"/> None <input type="checkbox"/> Yes How many per week?
Alcohol	<input type="checkbox"/> None <input type="checkbox"/> Yes How many drinks per week? <span style="float: right;">What type of Alcohol?</span>
Coffee	<input type="checkbox"/> None <input type="checkbox"/> Yes How many cups per week?
Recreational Drugs	<input type="checkbox"/> None <input type="checkbox"/> Yes Types? <span style="float: right;">Frequency? <span style="margin-left: 50px;">Years of Usage?</span></span>
Exercise	<input type="checkbox"/> None <input type="checkbox"/> Yes Hours/Days per week? <span style="float: right;">Types?</span>
Water	<input type="checkbox"/> None <input type="checkbox"/> Yes Glasses per day?
Soft Drinks	<input type="checkbox"/> None <input type="checkbox"/> Yes Amount per week? <span style="float: right;">Types?</span>
Sleep	<input type="checkbox"/> None <input type="checkbox"/> Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desires per night?
Eating	Meals per day? <span style="float: right;">What types of food do you eat?</span> Do you consider your diet healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain

**DATE OF LAST:**

Physical Examination	By Whom?	Results?
Blood Work	By Whom?	Results
Bone Density Study	By Whom?	Results?
Mammogram	By Whom?	Results?
Pelvic Exam	By Whom?	Results?
Self Breast Exam	Regularity	
Digital Prostate Exam	Results	
EKG	Results	
PSA Level	Results	
Chest X-rays	Results	
Echocardiogram	Results	
Spinal X-rays	By Whom?	Where are they located?
MRI/Cat Scan	Results	Where are they located?
Other Tests		

Check the first box of any of the following conditions you have HAD, and check the second box of anything you HAVE.

<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Pneumonia	<input type="checkbox"/> <input type="checkbox"/> Infective Disease
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Fungal Infection
<input type="checkbox"/> <input type="checkbox"/> Tumors	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> <input type="checkbox"/> Herpes
<input type="checkbox"/> <input type="checkbox"/> Alcoholism	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Drug Addiction	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Parasites	<input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> <input type="checkbox"/> Venereal Infection	<input type="checkbox"/> <input type="checkbox"/> Chicken Pox

NERVOUS SYSTEM	EENT	GI	MUSCULOSKELETAL
<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Vision Problems	<input type="checkbox"/> <input type="checkbox"/> Poor/Excess Appetite	<input type="checkbox"/> <input type="checkbox"/> Jaw Pain
<input type="checkbox"/> <input type="checkbox"/> Memory Loss	<input type="checkbox"/> <input type="checkbox"/> Flashing Lights	<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> <input type="checkbox"/> Confusion	<input type="checkbox"/> <input type="checkbox"/> Black Spots	<input type="checkbox"/> <input type="checkbox"/> Frequent Nausea	<input type="checkbox"/> <input type="checkbox"/> Face Pain
<input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> Blurriness	<input type="checkbox"/> <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/> Neck Pain
<input type="checkbox"/> <input type="checkbox"/> Fainting	<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Black/Bloody Stools	<input type="checkbox"/> <input type="checkbox"/> Arm/Elbow Pain
<input type="checkbox"/> <input type="checkbox"/> Convulsions	<input type="checkbox"/> <input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> <input type="checkbox"/> Digestive Problems	<input type="checkbox"/> <input type="checkbox"/> Wrist/Hand Pain
<input type="checkbox"/> <input type="checkbox"/> Weakness	<input type="checkbox"/> <input type="checkbox"/> Swallowing Difficulty	<input type="checkbox"/> <input type="checkbox"/> Abdominal Cramping	<input type="checkbox"/> <input type="checkbox"/> Mid Back Pain
<input type="checkbox"/> <input type="checkbox"/> Poor Balance		<input type="checkbox"/> <input type="checkbox"/> Gas/Bloating after meals	<input type="checkbox"/> <input type="checkbox"/> Lower Back Pain
<input type="checkbox"/> <input type="checkbox"/> Twitches/Tremor		<input type="checkbox"/> <input type="checkbox"/> Heartburn	<input type="checkbox"/> <input type="checkbox"/> Thigh/Knee Pain
<input type="checkbox"/> <input type="checkbox"/> Cold/Tingle Extremities	<input type="checkbox"/> <input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> Weight Problems	<input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain
<input type="checkbox"/> <input type="checkbox"/> Sleeping Difficulties	<input type="checkbox"/> <input type="checkbox"/> Painful Urination	<input type="checkbox"/> <input type="checkbox"/> Gall Bladder Problems	<input type="checkbox"/> <input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Incontinence	<input type="checkbox"/> <input type="checkbox"/> Liver Problems	<input type="checkbox"/> <input type="checkbox"/> Leg/Arm Fatigue
<input type="checkbox"/> <input type="checkbox"/> C-V	<input type="checkbox"/> <input type="checkbox"/> Discolored Urine		
<input type="checkbox"/> <input type="checkbox"/> Chest Pain		<input type="checkbox"/> <input type="checkbox"/> GENERAL	<input type="checkbox"/> <input type="checkbox"/> Cold hands & feet
<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> REPRODUCTIVE	<input type="checkbox"/> <input type="checkbox"/> Low energy/stamina	<input type="checkbox"/> <input type="checkbox"/> Weight issues
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Erectile Difficulties	<input type="checkbox"/> <input type="checkbox"/> Inability to lose weight	<input type="checkbox"/> <input type="checkbox"/> Hair loss
<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> <input type="checkbox"/> Dry skin/hair	<input type="checkbox"/> <input type="checkbox"/> Swelling/puffiness
<input type="checkbox"/> <input type="checkbox"/> Lung/Congestion Prob	<input type="checkbox"/> <input type="checkbox"/> Menstrual Irregularity	<input type="checkbox"/> <input type="checkbox"/> Thinning hair/eyebrows	<input type="checkbox"/> <input type="checkbox"/> Hives/acne/pimples
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Menstrual Cramping	<input type="checkbox"/> <input type="checkbox"/> General aches/pain	<input type="checkbox"/> <input type="checkbox"/> Low body temperature
<input type="checkbox"/> <input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> <input type="checkbox"/> Poor sex drive	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Allergies

How often do you have a bowel movement?	Are your movements consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do your stools <input type="checkbox"/> Float or <input type="checkbox"/> Sink?	Do you experience any urgency, dribbling, or incontinence?
How many times a day do you urinate?	Is this consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No