Medical History Template

The purpose of this form is to understand your past and present medical history.

What Complaint(s) Brings You In Today

Primary Complaint

Date primary complaint began

% of Day 1st Symptom Present

Bouts of pain last (hours/days)

Secondary Complaint

Date secondary complaint began

% of Day 2nd Symptom Present

Bouts of pain last (hours/days)

Additional Complaints or More Details:

Xray, MRI or Testing Recently?

I describe my pain as (dull, achy, hollow, heavy, colicky, pulling, distending, sharp, stabbing, spasm, sore, tight, throbbing, stiff, other?)

These actions or activities are difficult or worsen my complaint(s):

- [ ] Walking
- [ ] Sitting
- [ ] Standing
- [ ] Laying
- [ ] Bending
- [ ] Lifting
- [ ] Twisting
- [ ] Activity Or Exercise
- [ ] Rest
- [ ] Thinking, Remembering
- [ ] Sleep Quality
- [ ] Activities Of Daily Living
- [ ] Self Care/Grooming
- [ ] Driving
- [ ] Computer Or Desk Work

In the area of my pain, I will notice the following symptoms sometimes, often or all of the time.

- [ ] Heat In Area Of Pain
- [ ] Cold In Area Of Pain
- [ ] Swelling
- [ ] Tingling
- [ ] Pins & Needles
- [ ] Numbness
- [ ] Burning
- [ ] Loss Of Sensation

Pain worsens with hot, cold, dry, damp, wind, morning, afternoon, evening, eating, seasonal, changes in weather, stress, pressure

Pain is better with hot, cold, dry, damp, wind, morning, afternoon, evening, eating, seasonal, weather changes, meds, relaxation

What Treatment Have You Recieved For The Above Condition(s)?

Does pain feel fixed in location? Does it move or radiate out/away?

Tell Us About Your Lifestyle

Do you follow a particular diet plan? (keto, low carb, whole 30, etc)

Eat Raw And Cold Foods Often

- Yes
- No

Exercise? What do you do?

Mark The Ones That Describe You

- Drink Caffeine Most Days
- Sugary Drinks Most Days
- Drink Alcohol Most Days
- Smoke Marijuana Often
- Irregular Eating Habits
- Eat When Stress Is High
- High Protein, Low Carbs
- High Carb, Low Protein
- Crave Sweets
- Vegetarian or Vegan
- High Fruit & Veg Intake
- Low Fruit & Veg Intake
- Sudden Drops In Energy
- Work Swing Shifts
- Exposure To Toxins

Recreational Drugs?

Stress Level (Scale 1-10/10)

What Do You Do When You Need To Release Stress Or Relax?

Have You Ever Been A Smoker?

- Yes
- No

Do You Smoke Now?

- Yes
- No

If Yes, How Many Per Day?

Sleep Quality: I Fall Asleep

- Immediately
- Within 10-15 Minutes
- After A Long While

Sleep Quality: I Typically Wake

- Frequently
- No More Than 1-2 Times
- Refreshed In The Morning

Please indicate if you are taking any of the following:

- diet pills, appetite suppressants
- antacids (Tums, Mylanta)
- laxatives
- anti inflammatories (Advil, Aleve)
- cortisone or other steroids
- pain relievers (Tylenol, aspirin)
- blood thinners (warfarin, coumadin)
- tranquilizers, sedatives
- sleeping aids

If You Could Improve 1 Thing In Your Life, What Would It Be?

Current State of Health

How Would You Describe Your Current Health Condition?

- Excellent
- Good
- Fair
- Poor
- Chronically Unwell
- I am in the best health of my life!

My Body Temperature Feels?

- Hot
- Cold
- Normal
- Chills
- Fever
- Chills And Fever
- Alternating Hot/Cold
- Night Sweats
- Tidal Fever/Hot Flashes

If you experience any irregularity in sweating, please detail below.

- [ ] Profuse Sweating
- [ ] Unable To Sweat
- [ ] Easy To Sweat
- [ ] Night Sweat
- [ ] Morning Sweat
- [ ] Spontaneous Sweat
- [ ] Sweat Has Odor
- [ ] Rash Accompanies
- [ ] Easily Catch Colds

General Symptoms

- [ ] Edema
- [ ] Bruise Easy
- [ ] Muscle Tightness
- [ ] Loss of Balance
- [ ] Tremors
- [ ] Lack of Coordination
- [ ] General Muscle Weakness
- [ ] Fatigue
- [ ] Dizziness/Vertigo
- [ ] Insomnia
- [ ] Loss of/Poor Memory
- [ ] Poor Appetite
- [ ] Low Thirst
- [ ] Strong Thirst
- [ ] Panic Attacks
- [ ] Foggy Headed
- [ ] Full Body Aches/Pains
- [ ] Voracious Appetite
- [ ] Aversion To Cold
- [ ] Aversion To Wind
- [ ] Aversion To Heat

Skin And Hair

- [ ] Rashes
- [ ] Eczema
- [ ] Psoriasis
- [ ] Acne
- [ ] Ulcerations
- [ ] Hives
- [ ] Itching
- [ ] Fungal Infections
- [ ] Dandruff
- [ ] Hair Thinning
- [ ] Hair Loss

Head, Eyes, Ears, Nose & Throat Symptoms

- [ ] Dry Eyes
- [ ] Red Eyes
- [ ] Blurry Vision
- [ ] Poor Night Vision
- [ ] Floaters
- [ ] Eye Strain
- [ ] Difficult to Focus
- [ ] Cataracts
- [ ] Glasses/Contacts
- [ ] Ear Ringing: High Pitch
- [ ] Ear Ringing: Low Pitch
- [ ] Poor Hearing
- [ ] Plugged Sinuses
- [ ] Grinding Teeth
- [ ] Dental Problems
- [ ] Hoarse Voice
- [ ] Headaches
- [ ] Concussion
- [ ] Mouth Sores/Ulcers
- [ ] Migraines
- [ ] Nose Bleeds
- [ ] TMJ
- [ ] Facial Pain
- [ ] Ear Aches
- [ ] Sore Throat
- [ ] Plum Pit Feeling in Throat
- [ ] Excess Saliva

Cardiovascular Symptoms, Signs & Diseases

- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Irregular Heart Beat
- [ ] Heart Beating Fast
- [ ] Heart Palpitations
- [ ] Cold Hand/Feet
- [ ] Swelling of Hand/Feet
- [ ] Phlebitis
- [ ] Chest Pain
- [ ] Fainting
- [ ] Left Arm Pain
- [ ] Varicose Veins

Respiratory Signs & Symptoms

- [ ] Dry Cough
- [ ] Wet Cough
- [ ] Bronchitis
- [ ] Phlegmy
- [ ] Pneumonia
- [ ] Asthma

- [ ] Pain When Breathing Deep
- [ ] Short of Breath
- [ ] Chest Tightness
- [ ] Post Nasal Drip
- [ ] Labored Breathing
- [ ] Breath Feels Hot

If You Are Prone To Sinus Problems, How Would You Describe Them?

- [ ] Congested Nose
- [ ] Runny Nose
- [ ] Postnasal drip
- [ ] Dry Nose
- [ ] Burning Nose
- [ ] Mucus: Clear
- [ ] Mucus: Yellow
- [ ] Mucus: Green
- [ ] Mucus: Brown
- [ ] Mucus: Blood Tinged
- [ ] Mucus: Thin
- [ ] Mucus: Thick
- [ ] Mucus: Mixed
- [ ] Mucus: Profuse
- [ ] Mucus: Scanty/Light

GastroIntestinal

- [ ] Nausea
- [ ] Constipation
- [ ] Diarrhea
- [ ] Gas
- [ ] Bloating
- [ ] Abdominal Pain/Cramp
- [ ] Hiccup
- [ ] Acid Regurgitation
- [ ] Belching
- [ ] Indigestion
- [ ] Bad Breath
- [ ] Rectal Pain
- [ ] Anal Fissures
- [ ] Itchy Anus
- [ ] Hemorrhoids

Do you have a bowel movement every day?

- ( ) Yes
- ( ) No

Number of bowel movements per day?

- [ ] 1-2
- [ ] 3 or more

Are Your Bowel Movements?

- [ ] Well Formed
- [ ] Soft
- [ ] Bad Smelling
- [ ] With Undigested Food
- [ ] Burning With Elimination
- [ ] Pressure In Rectum
- [ ] Ribbon-Like
- [ ] Incomplete
- [ ] Ball, pebble-like

Genitourinary

- [ ] Frequent Urination
- [ ] Wakes Up To Urinate
- [ ] Pain During Urination
- [ ] Incomplete Urination
- [ ] Decrease Flow
- [ ] Decrease Stream Power
- [ ] Unable to Hold Urine
- [ ] Bedwetting
- [ ] Urinary Tract Infection
- [ ] Smelly Urine
- [ ] Dark Yellow Urine
- [ ] Kidney Stones
- [ ] Wet Dreams
- [ ] Impotence (Men)
- [ ] Enlarged Prostate (Men)
- [ ] Low Semen Volume (Men)
- [ ] Premature Ejaculation
- [ ] Gental Itching
- [ ] Genital Sores
- [ ] High Libido
- [ ] Low Libido

Gynecological & Obstetrics (Women Only)

- [ ] Currently Pregnant
- [ ] Irregular Menses
- [ ] Menstrual Clots
- [ ] No Menstrual Cycle
- [ ] Endometriosis
- [ ] Ovarian Cysts
- [ ] PCOS - Cystic Ovary
- [ ] PMS
- [ ] PID
- [ ] Uterine Fibroids
- [ ] Vaginal Sores
- [ ] Frequent Yeast Infections
- [ ] Total hysterectomy
- [ ] Partial hysterectomy
- [ ] Breast tenderness or lumps
- [ ] Menopause
- [ ] Perimenopause
- [ ] Vaginal discharge

Gynecological

Birth Control, Please List Type?

Last Menstrual Period

Date of Last PAP

How Many Days Do You Bleed (During Period)?

Number of Days Between Periods?

Color of Menstrual Blood

What is Your Flow Like? (light, heavy, spotting, clots)

Obstetrics

How many months pregnant?

Previous Live Births?

Premature Births?

Any Miscarriages?

Previous Abortions?

IVF

Neuropsychological

Do You Experience/Feel Numbness of___?

- [ ] Face
- [ ] Shoulder
- [ ] Arms
- [ ] Wrists
- [ ] Fingers
- [ ] Toes
- [ ] Legs
- [ ] Ankles
- [ ] Foot

Frequent Emotions

- [ ] Irritability
- [ ] Anger
- [ ] Worried/Pensive
- [ ] Depression
- [ ] Lack Of Joy In Life
- [ ] Over Thinking
- [ ] Restlessness
- [ ] Anxiety
- [ ] Grief
- [ ] Tension
- [ ] Manic
- [ ] Sadness
- [ ] Stress
- [ ] Fear
- [ ] Suicidal

Paralysis

Other Neurological Issues

Tell Us About Your Past Medical History

Please Mark The Check Box If You CURRENTLY HAVE, or HAVE HAD These Conditions.

- [ ] Asthma
- [ ] Anemia
- [ ] Appendicitis
- [ ] Arteriosclerosis
- [ ] Bronchitis
- [ ] Bird Flu

- [ ] Colitis
- [ ] Chronic Fatigue
- [ ] Depression
- [ ] Epilepsy/Seizures
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Fibromyalgia
- [ ] Emphysema
- [ ] Eating Disorder
- [ ] Gout
- [ ] Gallstones
- [ ] Goiter
- [ ] Hepatitis C
- [ ] Heart Disease
- [ ] Hepatitis B
- [ ] HIV
- [ ] Hypertension
- [ ] High Cholesterol
- [ ] Hyper Thyroid
- [ ] Herpes Simplex
- [ ] High Blood Pressure
- [ ] Mental Illness
- [ ] Hypo Thyroid
- [ ] Low Blood Pressure
- [ ] Mono
- [ ] Meningitis
- [ ] Paralysis
- [ ] Pacemaker
- [ ] Mumps
- [ ] Pneumonia
- [ ] Polio
- [ ] PTSD
- [ ] Physical Abuse
- [ ] Kidney Stones
- [ ] Rheumatic Fever
- [ ] Reynaud's Disease
- [ ] Scarlet Fever
- [ ] STD's
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Uterine Fibroids

Addictions

Cancer? What Type?

Hospitalization, Operations and Significant Traumas

Your Family's Medical History

Such as: addictions, asthma, cancer, diabetes, liver disease, kidney disease, high blood pressure, low blood pressure, high cholesterol, heart disease, mental disease, strokes, thyroid disease, etc.