

Name: _____ Birth date: _____

Home Address: _____ Home phone: _____

City, State, Zip: _____ Work Phone: _____

Email : _____ Cell Phone: _____

Sex: M F

Usual Occupation: _____ Employer: _____

Employment Status: School Homemaker Disabled Retired
(please circle) Work: Full time Part time Unemployed

Referred by _____

Marital status _____ Number of children _____

Person to be contacted in case of emergency _____

Address: _____ Phone: _____

Hospitalizations: Start with most recent and list type of illness, month and year hospitalized, name of hospital, city and state.

#1: _____

#2: _____

#3: _____

Allergies: _____

Medications: (Type, Dosage, Frequency. Use extended sheet if necessary) _____

Supplements (Use extended sheet if necessary): _____

Check if you have been bothered *recently* by any of these problems.

- | | | |
|---------------------------------|------------------------------|--------------------------------|
| -- frequent/severe headaches | -- nausea | -- difficulty relaxing |
| -- back pains | -- vomiting | -- worry a lot |
| -- neck lumps or swelling | -- pain in abdomen | -- nail biting |
| -- loss of balance | -- bloated abdomen | -- difficulty making decisions |
| -- dizzy spells | -- constipation | -- lack of confidence |
| -- blackouts or fainting | -- loose bowels | -- scary dreams or thoughts |
| -- wear glasses | -- black stools | -- shy or sensitive |
| -- blurry vision | -- gray or whitish stools | -- dislike criticism |
| -- eyesight worsening | -- blood with stools | -- angered easily |
| -- see double | -- pain in rectum | -- annoyed by little things |
| -- see halos or lights | -- itching in rectum | -- family problems |
| -- eye pains or itching | -- frequent urination | -- problems at work |
| -- watering eyes | -- involuntary urination | -- lack of concentration |
| -- earaches | -- burning on urination | -- loss of memory |
| -- running ears | -- black or bloody urination | -- hopeless outlook |
| -- hearing difficulties | -- weak urine stream | -- feeling of desperation |
| -- noises in ears | -- difficulty starting urine | -- lonely or depressed |
| -- dental problems | -- constant urge to urinate | -- frequent crying |
| -- sore or bleeding gums | -- sexual difficulties | -- considered suicide |
| -- sore tongue | -- change of sexual energy | |
| -- congested nose | -- loss or gain of weight | MEN ONLY |
| -- running nose | -- loss of appetite | -- burning or discharge |
| -- sneezing spells | -- always hungry | -- swelling on/of testicles |
| -- head colds | -- fatigue or weariness | -- painful testicles |
| -- nosebleeds | -- fever or chills | |
| -- sore throat | -- night sweats | WOMEN ONLY |
| -- difficulty swallowing | -- motion sickness | -- missed periods |
| -- hoarse voice | -- warmer/colder than others | -- menstrual problems |
| -- wheezing or gasping | -- aching muscles or joints | -- bleeding between periods |
| -- cough up phlegm | -- swollen joints | -- heavy bleeding |
| -- cough up blood | -- back or shoulder pains | -- bearing down feelings |
| -- chest colds | -- weakness in arms or legs | -- vaginal discharge |
| -- rapid or skipped heart beats | -- painful feet | -- genital irritation |
| -- chest pains | -- leg cramps | -- pain on intercourse |
| -- shortness of breath | -- painful feet | -- swelling of breasts |
| -- swollen feet or ankles | -- trembling | -- hot flashes |
| -- armpits or groin swelling | -- numbness | ____ # of pregnancies |
| -- difficulty sleeping | -- skin problems | ____ # of births |
| -- motion sickness | -- scalp problems | ____ # of miscarriages |
| -- excessive sweating | -- bruise easily | ____ # of premature births |
| -- recurring indigestion | -- nervousness or anxiety | ____ # of caesarean sections |
| -- frequent belching | -- nervous with strangers | ____ # of abortions |

Comments/special problems: *The main reason for your visit today?* _____

What are you most sensitive to (e.g. noise, odors, light, pain)? _____

Describe an ideal day in terms of weather and temperature: _____

What are your fears? _____

Describe your hobbies: _____

(Women only) What symptoms do you experience premenstrually? _____

Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams:

How is your energy? Is there any particular time of day when it is lower or higher?

What environment do you feel most comfortable in? (e.g., desert, mountains, ocean, city)

How is your sexual interest/drive? _____

What food do you crave or most like to eat _____

What is your favorite color? _____

What foods do you most dislike? _____

How is your thirst? _____

At what temperature do you like fluids? _____

Are there any foods that you are sensitive to or allergic to? _____

Family History: Place an (X) in the appropriate columns for any illnesses that you or your relatives have had.

Illness	<u>Self</u>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Child #1</u>	<u>Child #2</u>	<u>Child #3</u>	<u>Grand -parent</u>
Allergies									
Anemia									
Arthritis/Gout									
Asthma									
Bleeding problems									
Cancer									
Epilepsy									
Diabetes									
Alcohol/Drugs									
Eczema									
Psoriasis									
Emphysema									
Heart trouble									
Hepatitis									
High Blood Press.									
Frequent Infections									
Kidney Problems									
Mental Illness									
Migraines									
Abnormal periods									
Pneumonia									
Polio									
Prostate problems									
Rheumatic fever									
Stomach problems									
Stroke									
Thyroid problems									
Tuberculosis									
Ulcers									
Venereal disease									
Weight problems									

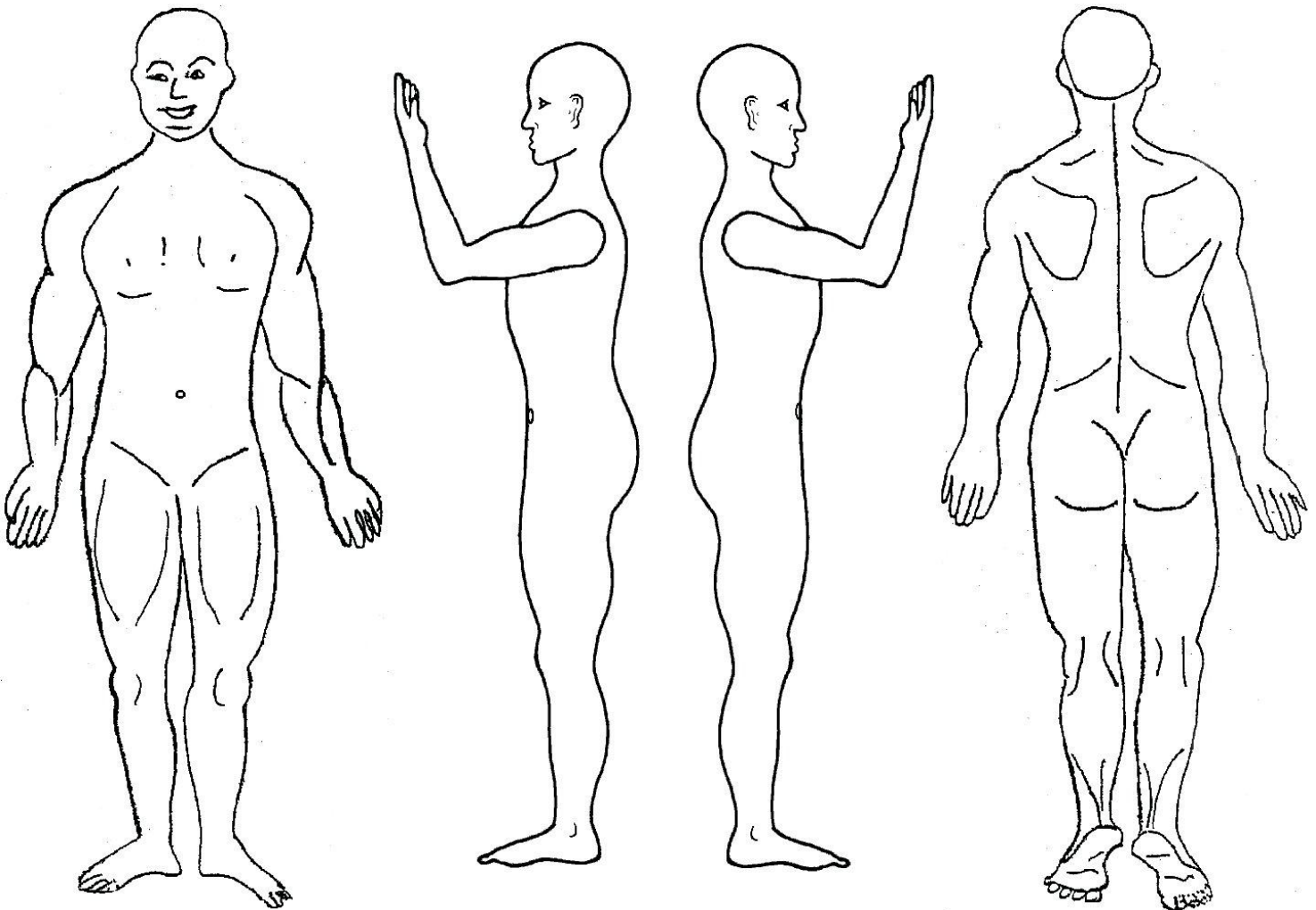
FOOD STRESSORS: Please indicate how many *times per week* you consume the following foods.

STIMULANTS	TOXIC OILS	DAIRY	HI HEATED FOODS
Coffee (or decaf)	Fried Foods	Cow's Milk	Bread
Black tea, Caffeine	Fast Food	Yogurt	Crackers
Soft Drinks, Colas	Potato/ Corn chips	Ice Cream	Bagels
Drinks w/ NutraSweet	Mayonnaise	Cottage Cheese	Buns
Alcohol, wine, beer etc	Margarine	Sour Cream	Pasta
Chocolate	Peanut Butter	Cheese	Muffins
Candy, pastry, sweets	Roasted Nuts	Kefir	Cookies

TESTS/IMMUNIZATIONS: Please indicate the years you have had these tests and immunizations.

YEAR	TESTS	YEAR	IMMUNIZATIONS
	Chest X-Ray		Smallpox
	Electrocardiogram		Tetanus
	TB Test		Polio
	GI Series		Typhoid
	Kidney X-Ray		Mumps, Measles
	Barium Enema		Flu
	Other X-Rays		Other

ADDITIONS: Please add here anything else you would like Dr.Ackerley to know about.



Directions

All Scars. Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, all Injection sites, tattoos, facelift scars, vasectomies, old burn areas.

All Trauma Areas. Please put a red "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury. Draw a line from each of the above injury areas and make a note of the type and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

DIET Please list a typical day's diet, including all snacks as well as main meals:

Breakfast

Lunch

Dinner

Snacks