

CONFIDENTIAL COMPREHENSIVE EXAMINATION FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Referred by \_\_\_\_\_

Birth Date \_\_\_\_\_ Email \_\_\_\_\_

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Major Complaint(s) \_\_\_\_\_

When did you first notice this problem(s)? \_\_\_\_\_

Have you had this condition in the past?     Yes    No   How recently? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is your condition:     Getting worse     Constant     Comes and goes

Medications/Drugs/Herbs you are currently taking:

List Surgeries/Operations you have had and dates:

Date of your last physical examination: \_\_\_\_\_ By whom: \_\_\_\_\_

Blood Pressure:     Normal     High     Low     Do not know

Do you have or have you ever had:

Asthma    Arthritis    Allergies    Heart Trouble    HIV    Herpes    Cancer    Diabetes

Eating disorder    Epilepsy    Kidney or Bladder Trouble    Gallstones    Ulcers

Do you have or have you ever had:

Chronic Fatigue    Hepatitis    Sudden weight gain or loss

Other \_\_\_\_\_

Has any member of your family had any of the above? If so, which member and what did they have:

\_\_\_\_\_

MUSCULOSKELETAL:

**Please draw in your pain pattern on the figure to the right:**

Do you have:

Repetitive strain injury    Tendonitis    Rheumatism

Loss of grip    Swollen knees/elbows    Leg cramps at night

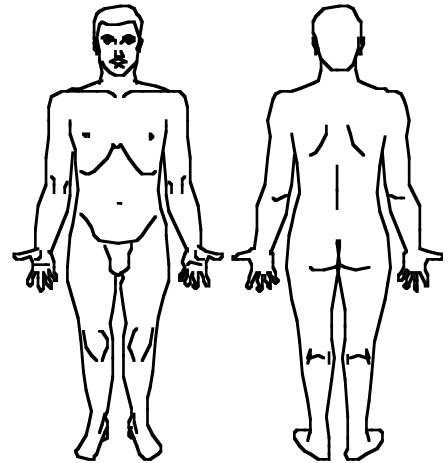
Weakness in legs/ankles    Stiff or sore all over

Muscle spasm/cramps    Painful joints

The pain is:    Minimal    Slight    Moderate    Severe

Sharp    Aching Numb    Deep pain    Burning    Dull    Superficial pain    Tingling

Worse or Better with heat    Worse or Better with cold    Worse in AM or PM    Better in AM or PM



EMOTIONS, LIFESTYLE AND SLEEP:

Do you have:    Panic attacks    Depression    Anxiety    Bad Temper    Nervousness

Poor memory    Difficult concentration    Other: \_\_\_\_\_

Are you:    Married/Stable relationship    Single

How does stress manifest in your body? \_\_\_\_\_

How do you relax? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

How is your energy level through out the day? \_\_\_\_\_

Are you currently in therapy:  Yes    No

How long do you usually sleep: \_\_\_\_\_ hours per night

Do you have difficulty with:

Falling asleep    Staying asleep    Disturbed sleep    Waking up at \_\_\_\_\_

Do you use tobacco?  Yes  No How many years? \_\_\_\_\_ How many per day? \_\_\_\_\_

Do you use marijuana?  Yes  No Other recreational drugs?  Yes  No

Type of Exercise: \_\_\_\_\_ How many times and how long per week \_\_\_\_\_

Do you get headaches or migraines?  Yes  No If so, what triggers them: \_\_\_\_\_

Where on your head do they manifest? \_\_\_\_\_

DIET:

**Please bring in a 3 day food diary for your first visit.**

If you are not able to do this, please fill out the following:

|           |       |       |       |        |       |
|-----------|-------|-------|-------|--------|-------|
| _____     | _____ | _____ | _____ | _____  | _____ |
| _____     | _____ | _____ | _____ | _____  | _____ |
| _____     | _____ | _____ | _____ | _____  | _____ |
| Breakfast | Snack | Lunch | Snack | Dinner | Snack |

Specific food cravings? \_\_\_\_\_ When? \_\_\_\_\_

List any food intolerances, allergies, or avoidances: \_\_\_\_\_

How many glasses or cups do you intake daily: Water \_\_\_\_\_ Soda \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_

Alcohol: \_\_\_\_\_ per day or week. Are you always thirsty?  Yes  No

Do you frequently eat when worried or rushed?  Yes  No

What percentage of your food is cooked? \_\_\_\_\_ Do you eat regularly?  Yes  No

GASTROINTESTINAL:

DO YOU HAVE:

Belching  Nausea  Vomiting  Ulcers  Bloating  Acid reflux  Heart burn

Regurgitation  Indigestion  Severe stomach pain  Other \_\_\_\_\_

Bowel movements: How often? \_\_\_\_\_ day/week Are they painful?  Yes  No

Do you have:

Irregular bowel movements  Constipation  Diarrhea  Gas  Burning

Hemorrhoids  Use laxatives  Undigested food in stool  Loose stool

Hard stool  Blood in stool  Itchiness Other \_\_\_\_\_

RESPIRATORY, EARS, EYES NOSE, THROAT:

- Do you have:  Frequent colds       Chronic runny nose       Chronic cough       Pain inhaling
- Shortness of breath on exertion/at rest       Asthma       Nose bleeds       Painful/red eyes
- Poor vision       Dizziness       See spots       Cold sores       Dry mouth
- Bleeding gums       Frequent sore throat       Ear pain       Ringing in ears
- Clogged or popping ears

FEMALES:

- Last monthly period: \_\_\_\_\_ Last PAP test: \_\_\_\_\_
- Age menses stopped: \_\_\_\_\_ Are you on BCP's?  Yes       No
- On average, how long is your cycle: \_\_\_\_\_
- Do you have:     Menstrual pain     Fibroids     Irregular menses     Clotting
- Heaving bleeding     Light scanty bleeding    Color of blood \_\_\_\_\_
- Discharge:  Yellow     Thick     Itchy     Odor       Breast Tenderness       Hot flashes
- Water retention     Mood changes     Endometriosis     Low or no sex drive
- # of Pregnancies \_\_\_\_\_ # of deliveries \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_
- Number of cesareans \_\_\_\_\_ Operations:  Cervix     Uterus     Ovaries     Other \_\_\_\_\_
- Pregnant?     Yes     No                      Trying to get pregnant?     Yes     No
- If you are trying to conceive, please fill out information if you know it;
- How long have you been trying \_\_\_\_\_ Are you charting ?  Yes       No
- FSH \_\_\_\_\_ Have you seen a fertility doctor?  Yes     No,    if yes who/where \_\_\_\_\_
- If you have a male partner, has his sperm been analyzed?  Yes     No
- Have you done a medicated cycle:  Yes       No    If yes, please be specific: \_\_\_\_\_
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MALES:

- Do you have:       Low sexual drive     Impotence       Discharge       Prostatitis
- Pain or burning while urinating       Premature ejaculation      Other \_\_\_\_\_