

BETWEEN HEAVEN AND EARTH H.C.

Name: _____ Date _____

Address: _____ City: _____ ST: ___ Zip: _____

Email: _____ Cell Phone _____

Date of birth: _____ Age: _____ Height: _____ Weight _____

Reason for visit today: _____

Date of onset (when you first began noticing the symptoms) _____

What aggravates the symptoms? _____

What makes it better? _____

Are you being treated or been treated for this by other health care professionals?

_____ Has it been effective? _____

Current medications, including herbs, vitamins and other supplements:

ALLERGIES: _____

Surgeries/ Operations you've had and the dates: _____

Medical History:

Do you have or have you had any of the following:

- Alcoholism Anemia Angina Anxiety Arthritis
- Asthma Cancer Depression Diabetes Digestive Problems
- Drug Addiction Emphysema Fatigue Heart Problems
- Hepatitis (A, B, C) Herpes High/ Low Blood Pressure
- HIV/ Aids Insomnia Low Blood Sugar Seizures
- Sleeping Problems Stroke Thyroid Tuberculosis
- Ulcers Weight Loss or Gain

Other _____

Do any family members suffer from any of the previous disorders? Who?

Which of the following are a part of your lifestyle? How much? How often?

- Alcohol Smoking Sugar/Sweets
- Coffee Recreational drug use

On a scale of 1 to 10, how would you rate your stress level? _____

How does stress affect you? (Headaches, Insomnia, Stomach upset etc.)

What do you do to relieve it? _____

Energy level: High Low What time of day is best for you? _____

Appetite: Excessive Poor Keeps Changing

Do you eat three meals day? _____ Do you follow a particular diet? _____

Do you eat fruits and veggies daily? _____ Feel tired or weak if meal is missed? _____

Feel tired after eating? _____

Thirst: Excessive Never Thirsty How much water daily? _____

Do you exercise? What type? How often? _____

Review of symptoms:

Do you have any of the following:

Head/ Throat:

Headaches Migraines Dizziness Eyeglasses/Contacts

Blurred Vision Eye Pain Dry Eyes Cataracts Spots in Vision

Earaches Ringing in ears Poor Hearing Dry Mouth

Increased Saliva Bad Breath Coated Tongue Sores in Mouth or on

Lips Teeth Problems Gum Problems Grinding Teeth Jaw Clicking

Sinus Problems Nose Bleeds Sneezing Sore Throat Difficulty

Swallowing Hoarseness Dry Throat Mucous

Swollen Glands Feeling as if Something in Throat

Other Issues in this Area _____

Chest:

- Chest Pain/ Pressure/Tightness
- Fainting
- Irregular Beats
- Palpitations
- Shortness of Breath
- Difficulty Breathing
- Difficulty Lying Down
- Asthma
- Bronchitis
- Cough
- Coughing Blood
- Coughing Phlegm
- Yellow
- White
- Clear

Digestive:

- Belching
- Nausea
- Vomiting
- Stomach/Abdominal Pain
- Bloating
- Gas
- Pain after Eating
- Diarrhea
- Constipation
- Black Stools
- Hemorrhoids
- Rectal Pain
- Rectal Bleeding
- Colon Problems
- Laxative use
- Loose Stools
- Diarrhea in the Morning
- Number of Bowel Movements a Day _____
- Color _____

Urinary:

- Frequent/ Difficult/ Painful/ Burning Urination
- Blood in Urine
- Kidney Stones
- Urgency to Urinate
- Can't Hold Urine
- Waking to Urinate at Night
- If yes, what time? _____

Skin/Hair:

- Rashes
- Acne
- Bruise Easily
- Itching
- Eczema
- Psoriasis
- Falling Hair
- Dandruff
- Hives
- Changes in Moles, Freckles etc.
- Excessive Sweat
- Night Sweat
- Rarely Sweat
- Other Skin Issues _____

Neuropsychological:

- Nervousness
- Anxiety
- Depression
- Irritable
- Easy Anger
- Frequent Crying
- Mood Changes
- Memory Loss
- Confusion
- Poor Concentration
- Foggy Thinking
- Numbness/ Tingling
- Cold Hands or Feet
- Nerve Pain
- Loss of Coordination
- Tremors/Tics
- Sciatica

Sleep:

- Difficulty Falling Asleep
- Difficulty Staying Asleep
- Excessive Dreaming
- How many hours do you sleep each night? _____
- Wake up Tired
- Rested
- Drowsy during the day

Musculoskeletal: Pain in:

- Neck
- Shoulders
- Between Shoulders
- Arms/Hands
- Elbows
- Upper Back
- Mid Back
- Lower Back
- Knees
- Joints ache
- Swollen joints
- Stiffness
- Muscles Cramps at Night
- Arthritis
- Bursitis
- Muscle Spasms
- Injuries/ Broken Bones Etc _____

Women:

Are you Pregnant? _____ If so, How far along? _____

Number of Pregnancies _____ Number of Births _____ Premature Births _____

Miscarriages _____ Abortions _____

What form of Birth Control do you use? _____ Do you have PAP Smears?

_____ How Often? _____ Age at First Period _____ Age at Menopause, if applicable _____

Any of the following?

- Irregular Periods
- Painful/ Difficult Periods
- Heavy Bleeding
- Light Bleeding
- Cramping
- Bloating
- Clots
- Constipation
- Breast Swelling/Tenderness

Relative to the color of blood from a wound, is your menstrual blood:

the same color ___ more red ___ more pale ___ purple brown ___ black ___

How many days do you bleed? ___

Do you have any of the following pre-menstrual symptoms:

- Irritability
- Depression
- Crying
- Holding Fluids
- Sleep Changes
- Breast Tenderness/Swelling
- Constipation
- Temperature Changes
- Food/Sweet cravings
- Lower Back Pain

Any other issues around your period: _____

Do you have high or low sexual desire? _____ Vaginal Dryness or Sores _____

Any other concerns about these? _____

Men:

- Low sex drive
- Lack of sex drive
- Impotence
- Premature ejaculation
- Pain with Ejaculation
- Urinary Frequency
- Prostate Problems
- Discharge
- Genital/Testicular Pain

I have provided correct and complete information to the best of my knowledge

Signature: _____