pearl
NATURAL HEALTH

Name_____ Date_____

Address _____

City_____ State_____ Zip code_____

Phone (hm)_____ (wk) _____ E-mail_____

Age_____ Date of birth _____ Gender ☐ female ☐ male

Place of birth: _____

Employer_____ Social Security # _____

☐ Married ☐ Partnership ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Live with: ☐ Spouse or partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Next of kin or other to reach in case of emergency: _____

Relationship_____ Phone_____

Address_____

How did you hear about our clinic?_____

Insurance information

Health insurance _____ Phone#: _____

Address_____

City_____ State _____ Zip code _____

Subscriber's Name_____Date of Birth:_____

I.D.#_____ Group/Policy # _____

We hope you will answer the questions on this medical history form as thoughtfully as possible. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking care. However, the answers to these questions, as well as the information you provide in the office, will determine the individualized approaches we take to begin your treatment. ALL THE INFORMATION IN THIS QUESTIONNAIRE IS CONFIDENTIAL BY LAW.

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CONTEXT OF CARE REVIEW

Why did you choose this clinic?

What do you know about our approach to your healthcare?

What *three* expectations do you have from your *first visit* to our clinic?

What are your *long-term goals* in working with our clinic?

What is your present level of motivation to address any underlying causes of your signs and symptoms?

Rate from 0 to 10, 10 being 100% motivated.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe contribute to and support your health?

What potential obstacles to making lifestyle changes or embarking on an intensive therapeutic program do you forsee?

What do you love to do that gives you a sense of satisfaction?
0=no fulfillment/10=great fulfillment

Career	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Health	1	2	3	4	5	6	7	8	9	10
Significant Other/Romance	1	2	3	4	5	6	7	8	9	10
Fun & Recreation	1	2	3	4	5	6	7	8	9	10
Family and Friends	1	2	3	4	5	6	7	8	9	10
Friends	1	2	3	4	5	6	7	8	9	10
Physical	1	2	3	4	5	6	7	8	9	10
Environment	1	2	3	4	5	6	7	8	9	10

Are you currently receiving healthcare? Y N

If yes, from whom?_____

If no, when and where did you last receive medical or healthcare? _____

What was the reason? _____

What are your most important health concerns? List as many as you can in order of importance:

(1) _____
(2) _____
(3) _____
(4) _____
(5) _____
(6) _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and indicate who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hayfever	Hives	Autoimmune Disease
Thyroid problems			

Any other relevant family history? _____
What is your family heritage?_____

CHILDHOOD ILLNESSES

Please circle whether you had any of the following as a child:

Rheumatic Fever	Diphtheria	Scarlet Fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATION AND SURGERY

What hospitalizations and surgeries have you had?

_____year:_____ _____year:_____
_____year:_____ _____year:_____
_____year:_____ _____year:_____

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other_____	

ALLERGIES

Are you hypersensitive or allergic any drugs, foods, environmentals, or chemicals? _____

_____

MEDICATIONS

Please list **any** prescription medications, over-the-counter medications, vitamins, or other supplements you are taking:

(1) _____ (5)_____

(2)_____ (6)_____

(3)_____ (7_____

(4) _____ (8)_____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks: _____

To drink:_____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you **have now**; **N**=**never had**; **P**=a condition you **have had** before

HABITS

Main interests and hobbies?

_____

Do you exercise? What Kind?_____	Y	N		Read? How many hours?____	Y	N	
Have a supportive relationship?	Y	N		Do you use alcoholic beverages?	Y	N	P
Have a history of abuse?	Y	N		Treated for alcoholism?	Y	N	P
Any major traumas?	Y	N	P	Do you use tobacco?	Y	N	P
Use recreational drugs?	Y	N	P	Smoked previously? # yrs_____	Y	N	P
Been treated for drug dependence?	Y	N	P				
Enjoy your work?	Y	N					
Spend time outside?	Y	N		Religious or spiritual practice?	Y	N	P
Watch television?	Y	N		Take vacations?	Y	N	

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REVIEW OF SYSTEMS

MENTAL/EMOTIONAL

Treated for emotional problems?	Y	N	P	Depression?	Y	N	P
Mood swings?	Y	N	P	Anxiety or nervousness?	Y	N	P
Considered/Attempted suicide?	Y	N	P	Tension?	Y	N	P
Poor concentration?	Y	N	P	Memory problems?	Y	N	P
Fears, phobias? Please specify: _____							
Increased irritability?	Y	N	P	Mental mistakes (dyslexia, etc.)	Y	N	P
Angered easily?	Y	N	P	Hallucinations, hearing voices?	Y	N	P

ENDOCRINE

Hypothyroid?	Y	N	P	Heat or cold intolerance?	Y	N	P
Hypoglycemia?	Y	N	P	Diabetes?	Y	N	P
Excessive thirst?	Y	N	P	Excessive hunger?	Y	N	P
Fatigue?	Y	N	P	Seasonal depression?	Y	N	P

IMMUNE

Vaccinations?	Y	N	P	Reactions to vaccinations?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Chronic infections?	Y	N	P
Chronically swollen glands?	Y	N	P	Slow wound healing?	Y	N	P

NEUROLOGIC

Seizures?	Y	N	P	Paralysis?	Y	N	P
Muscle weakness?	Y	N	P	Numbness or tingling?	Y	N	P
Loss of memory?	Y	N	P	Easily stressed?	Y	N	P
Vertigo or Dizziness?	Y	N	P	Loss of balance?	Y	N	P

SKIN

Rashes?	Y	N	P	Eczema, hives?	Y	N	P
Acne, boils?	Y	N	P	Itching?	Y	N	P
Color change?	Y	N	P	Perpetual hair loss?	Y	N	P
Lumps?	Y	N	P	Night sweats?	Y	N	P

HEAD

Headaches?	Y	N	P	Head injury	Y	N	P
Migraines?	Y	N	P	Jaw/TMJ problems?	Y	N	P
Hair loss?	Y	N	P	Feeling of heaviness?	Y	N	P
Sensitive scalp?	Y	N	P	Marked sweating?	Y	N	P
Eruptions?	Y	N	P	Dandruff?	Y	N	P

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FACE

Pain/neuralgia?	Y	N	P	Excessive sweating	Y	N	P
Acne?	Y	N	P	Discoloration?	Y	N	P
Twitching?	Y	N	P				

EYES

Spots in eyes?	Y	N	P	Cataracts?	Y	N	P
Impaired vision?	Y	N	P	Glasses or contacts?	Y	N	P
Blurriness?	Y	N	P	Eye pain, strain?	Y	N	P
Color blindness?	Y	N	P	Tearing or dryness?	Y	N	P
Double vision?	Y	N	P	Glaucoma?	Y	N	P
Aversion to sun?	Y	N	P	Itchy eyes?	Y	N	P
Sensation of sand?	Y	N	P	Excessive tearing?	Y	N	P
Redness?	Y	N	P	Sties?	Y	N	P

EARS

Impaired hearing?	Y	N	P	Ringing/noises in ears?	Y	N	P
Earaches?	Y	N	P	Chronic ear infections?	Y	N	P
Discharge from ears?	Y	N	P	Itching in ears?	Y	N	P

NOSE AND SINUSES

Frequent colds?	Y	N	P	Nose bleeds?	Y	N	P
Stuffiness?	Y	N	P	Hayfever?	Y	N	P
Sinus problems?	Y	N	P	Loss of smell?	Y	N	P
Breathing problems?	Y	N	P	Frequent sneezing?	Y	N	P
Eruptions, sores?	Y	N	P				

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	Copious saliva?	Y	N	P
Teeth grinding?	Y	N	P	Sore tongue/lips?	Y	N	P
Loss of teeth?	Y	N	P	Hoarseness?	Y	N	P
Gum problems?	Y	N	P	Jaw clicks?	Y	N	P
Dental cavities?	Y	N	P	Canker sores?	Y	N	P
Fever blisters?	Y	N	P	Cracked lips?	Y	N	P
Tooth sensitivity?	Y	N	P	Cracks on tongue?	Y	N	P
Peculiar taste?	Y	N	P	Bad breath?	Y	N	P

NECK

Lumps?	Y	N	P	Swollen glands?	Y	N	P
Goiter?	Y	N	P	Pain or stiffness?	Y	N	P
Peculiar feelings?	Y	N	P	Choking feeling?	Y	N	P

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RESPIRATORY

Cough?	Y	N	P	Spitting up mucus?	Y	N	P
Spitting up blood?	Y	N	P	Wheezing?	Y	N	P
Asthma?	Y	N	P	Bronchitis?	Y	N	P
Pneumonia?	Y	N	P	Pleurisy?	Y	N	P
Emphysema?	Y	N	P	Difficulty breathing walking	Y	N	P
Pain breathing?	Y	N	P	Difficulty breathing lying down	Y	N	P
Shortness of breath at night?	Y	N	P	Climbing stairs difficult	Y	N	P
Persistent hoarseness?	Y	N	P				

CARDIOVASCULAR

Heart disease?	Y	N	P	Chest pain at rest?	Y	N	P
High/Low Blood Pressure	Y	N	P	Chest pain walking/exertion?	Y	N	P
Blood clots?	Y	N	P	Leg pain unrelated to injury?	Y	N	P
Fainting?	Y	N	P	Easy bruising or bleeding?	Y	N	P
Ankle or leg swelling?	Y	N	P	Phlebitis?	Y	N	P
Rheumatic Fever?	Y	N	P				

GASTROINTESTINAL

Heartburn?	Y	N	P	Bloating?	Y	N	P
Indigestion?	Y	N	P	Belching?	Y	N	P
Frequent nausea?	Y	N	P	Flatulence/passing gas	Y	N	P
Frequent vomiting	Y	N	P	Marked thirst?	Y	N	P
Diarrhea?	Y	N	P	Thirstless?	Y	N	P
Constipation?	Y	N	P	Appetite increased?	Y	N	P
Bloody stools?	Y	N	P	Appetite decreased?	Y	N	P
Light colored stools?	Y	N	P	Hurried eating?	Y	N	P
Rectal pain?	Y	N	P	Loss of taste?	Y	N	P
Rectal itching?	Y	N	P	Difficulty swallowing?	Y	N	P
Worse from missing a meal?	Y	N	P	Abdominal or stomach pain?	Y	N	P
Gall bladder disease?	Y	N	P	Ulcer?	Y	N	P
Hemorrhoids?	Y	N	P	Bowel movements: How often?			
				_____			

URINARY

Frequent urination?	Y	N	P	Strong smelling urine?	Y	N	P
Frequency at night?	Y	N	P	Inability to hold urine?			
Painful urination?	Y	N	P	Blood in urine?	Y	N	P
Difficult urination?	Y	N	P	Involuntary urination?	Y	N	P
Frequent infections?	Y	N	P	Frequency at night?			

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MALE SYMPTOMS

Hernias?	Y	N	P	Frequent masturbation?	Y	N	P
Testicular pain?	Y	N	P	Difficult or loss of erection?	Y	N	P
Venereal disease?	Y	N	P	Painful erections?	Y	N	P
Lump, swelling, or masses in testicles?	Y	N	P	Infertility?	Y	N	P
Prostate disease?	Y	N	P	Chlamydia, gonorrhea, syphilis?	Y	N	P
Discharge or sores?	Y	N	P	Herpes?	Y	N	P

FEMALE SYMPTOMS

Age of first menses? _____				Ovarian cysts?	Y	N	P
Age of last menses (if menopausal)? _____				Vaginal infections/discharge?	Y	N	P
Length of cycle:	Y	N	P	Vaginal dryness?	Y	N	P
Are cycles regular?	Y	N	P	Vaginal itching?	Y	N	P
Bleeding between cycles?	Y	N	P	Swelling or lumps in breast?	Y	N	P
Duration of menses?	Y	N	P	Nipple discharges?	Y	N	P
Heavy or excessive flow?	Y	N	P	Painful intercourse?	Y	N	P
PMS?	Y	N	P	Difficulty conceiving?	Y	N	P
Abnormal PAPS?	Y	N	P	Number of pregnancies? _____			
Cervical dysplasia?	Y	N	P	Number of live births? _____			
Sexual difficulties?	Y	N	P	Number of miscarriages? _____			
Gonorrhea?	Y	N	P	Number of abortions? _____			
Chlamydia?	Y	N	P	Birth Control Pills or Hormones?	Y	N	P
Condyloma?	Y	N	P	Menopausal symptoms?	Y	N	P
Endometriosis?	Y	N	P				
Uterine fibroids?	Y	N	P				

SKIN

Warts?	Y	N	P	Pustules?	Y	N	P
Cysts?	Y	N	P	Discoloration?	Y	N	P
Infections?	Y	N	P	Easy bruising?	Y	N	P
Hives or urticaria?	Y	N	P	Skin cracks?	Y	N	P
Swollen glands?	Y	N	P				
Eczema?	Y	N	P				

PERSPIRATION

Excessive sweating?	Y	N	P	Strong odor of perspiration?	Y	N	P
Specify part of body				Night sweats?	Y	N	P

_____

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SLEEP

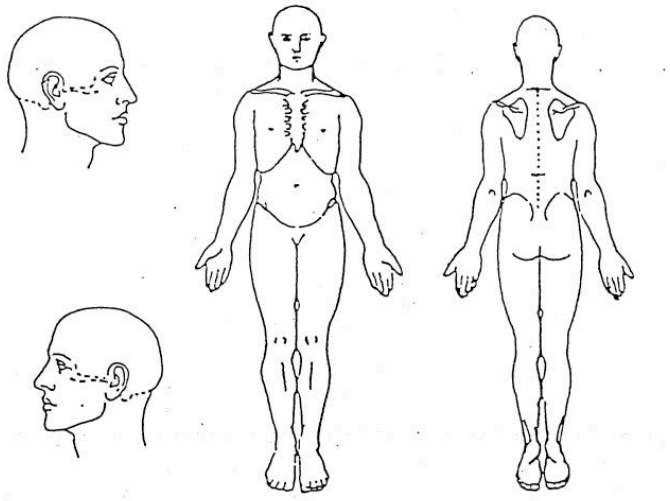
Difficulty falling asleep?	Y	N	P	Favorite sleep position? _____		
Jerking on falling asleep?	Y	N	P	Stay covered during the night?	Y	N
Interrupted sleep?	Y	N	P	Stick feet out of covers?	Y	N
Sleep walking?	Y	N	P	Wear socks to bed?	Y	N
Talking in sleep?	Y	N	P	Feeling on waking in morning? _____		
Grinding teeth in sleep?	Y	N	P	Feeling on waking from nap?_____		

Number of hours per night? _____

MUSCULOSKELETAL

Pain?	Y	N	P	Coldness?	Y	N	P
Stiffness?	Y	N	P	Twitching?	Y	N	P
Swelling?	Y	N	P	Tremors?	Y	N	P
Numbness?	Y	N	P	Weakness?	Y	N	P
Tightness?	Y	N	P	Paralysis?	Y	N	P
Burning/heat?	Y	N	P	Shooting pains?	Y	N	P

Please diagram pain/s



Describe the quality of the pain/s:_____

Describe the intensity of the pain/s:_____

Describe the frequency or timing of the pain/s:
_____

What makes the pain/s better?_____
_____

What makes the pain/s worse? _____
_____

Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page or another sheet of paper.