Medical History Assessment Form

Family History Self Mother Father Sister Brother Grandparents Children

Age _____
Alcoholism _____
Allergies _____
Anemia _____
Arthritis _____
Asthma _____
Autoimmune Diseases _____
Bleeding/Bruising _____
Cancer _____
Convulsions/Epilepsy _____
Crohns / Colitis _____
Depression _____
Diabetes _____
Digestive Diseases _____
Hay fever _____
Herpes/Shingles _____
Hepatitis _____
HIV _____
Drug Addictions _____
Eczema/Psoriasis _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Frequent Infections _____
Kidney Diseases _____
Meniere's Disease _____
Mental Illness _____
Migraines _____
Pneumonia _____
Polio _____
Prostate Disorders _____
Rheumatoid Arthritis _____
Sinus Disorders _____
Strokes _____
Thyroid Disorders _____
Tuberculosis _____
Ulcers _____
Urinary Dysfunctions _____
Venereal Diseases _____
Weight Problems _____

1. **Childhood Illness:** (Please circle any that you have had)

   Scarlet Fever Diptheria Mumps Measles German Measles Chicken Pox

2. **Immunizations:** (Please circle any that you have had)

   SmallPox Polio Mumps Pneumonia Pertussis Tetanus Measles Diptheria Flu Hep-B

   Any side effects _____

3. **Hospitalizations / Surgeries:**

Date	Attending Physician	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Previous Diagnostic Tests:

	Date	Reason
EKG	_____	_____
Treadmill Stress	_____	_____
Cartoid Duplex Scan	_____	_____
Calcium Scoring	_____	_____
Thallium Stress Test	_____	_____
Venous Duplex Scan	_____	_____
Segmental Arterial Doppler	_____	_____
24-Hr Holter Moniter	_____	_____
Angiogram	_____	_____
Ultrasound Tests	_____	_____
GI Series	_____	_____
Gallbladder Tests	_____	_____
Kidney Series	_____	_____
Mammogram	_____	_____
Bone Mineral Density(Dexa)	_____	_____
Allergy Tests	_____	_____
Urine Tests	_____	_____
Saliva Tests	_____	_____
Stool Tests	_____	_____
Blood Tests	_____	_____
NAET	_____	_____
X-Rays	_____	_____
CAT Scans	_____	_____
MRI=s	_____	_____
NMR=s	_____	_____
EEG=s	_____	_____

5. Please list all allergies to any drugs, supplements, plants, foods, animals, environmental or metal toxins if applicable:

_____

_____

_____

_____

6. Living Environment

Urban _____ Suburban _____ Country _____ Mountains _____ Seaside _____ Lakeside _____

Type of heat: Gas _____ Electric _____ Radiant _____ Solar _____ Wood _____

Type of insulation: _____ Type of ventilation: A/C _____ Fans _____

Is the home? Dry _____ Damp _____ Dusty_____ Musty _____ Moldy _____ Old _____ New _____

Has it been treated for pests? _____ if so, which chemicals were used _____

Do you use? Air filters _____ Air cleaners _____ Humidifiers _____ Ionizer _____

What type of drinking water do you use at home? _____

Do you use feather or down comforters, covers, furniture or jackets? _____

Are there any animals at home? _____ What kind? _____

Do you use strong chemicals, cleaners, solvents, paints, pesticides, etc? _____

Do you use the microwave frequently? _____ Do you put plastic in the microwave? _____

Do you dye your hair _____ If so, how often _____ What type of dyes? _____

Do you have amalgam (silver) fillings? _____ Any dental problems? _____

Is the outside of your home? Noisy_____ Busy with traffic _____ Quiet _____ Varies _____

7. Habits

Please check the following habits that pertain to you:

Tobacco _____ Current packs _____ Past packs _____ Years of use _____ Nicotine patches _____

Sodas _____ # per day _____ # per week _____ Artificial sweeteners _____

Chocolate _____ # per day _____ # per week _____ Certain time of day _____

Caffeine _____ # cups per day _____ What time of day _____ Diet pills _____

Alcohol _____ # drinks per day _____ # drinks per week _____ Type of alcohol _____

Marijuana _____ # of joints per day _____ # of joints per week _____ Certain time of day _____

Other recreational drug use _____ What type _____ How often _____

Sleeping medication _____ What type _____ # of months _____ # of years _____

Sexual frequency _____ Are you satisfied with frequency _____ Are you frustrated with frequency _____

Gambling _____ How often _____ What type of gambling _____

Any repetitive rituals performed _____ How often _____ Duration _____ # of years _____

Do you feel that you have a problem with any of your habits _____ Have you been treated for any of your habits _____
If so, please explain the nature of treatments received: _____

_____

_____

_____

Did you feel that the treatments were effective? _____ Did you follow the treatment plan _____ If so, for how long were you committed to your treatment plan _____ What altered your recovery process _____

_____

8. Exercise / Activity

Is your job: Active _____ Sedentary _____

How many hours are you sitting daily? At work _____ At home _____ Driving _____

On the average, how much exercise do you do daily? None _____ 15 min. _____ 30 min. _____ 45 min. _____
1 hr. _____ 1 hr. 15 min. _____ 1 hr. 30min. _____ 1 hr. 45 min. _____ 2 hr. _____

Please describe the types of exercise, activities or sports that you perform _____

_____

_____

How many days per week do you engage in these activities? _____

Do you feel that you get enough exercise on a weekly basis? Yes _____ No _____ If no, why not? _____

_____

9. Stress Management

Would you consider yourself to be under: No stress _____ Acute stress _____ Chronic stress _____

If yes, please check the best description of your stress: Family _____ Relationship _____ Work related _____

School related _____ Personal _____ Illness _____ Travel _____ Legal _____ Disabilities _____

Do you feel that you handle your stress well? Yes _____ No _____

Do you feel that the stresses you are under are within your control? Yes _____ No _____

Do you awaken in the middle of the night replaying your day's events? Yes _____ No _____

Do you awaken in the middle of the night worried about the next day? Yes _____ No _____

How many hours do you work daily? Career _____ Childcare _____ Household _____ Garden _____

How many days a week do you work? _____ How many hours per week do you work? _____

How long is your commute to work? _____ Do you travel for work _____ If so, how often? _____
If the definition to Stress is not having enough hours to take care of yourself (sleeping, awakening rested, eating properly, exercising and relaxation), would you consider yourself to be a stressed person? _____

Check all items below that pertain to what you do to help handle your stresses: Exercise _____ Sleep _____ Read _____

Meditate _____ Yoga _____ Tai chi _____ Qi gong _____ Sports _____ Hiking _____ Walking _____

Sailing _____ Fishing _____ Water sports _____ Winter sports _____ Cycling _____ TV _____ Movies _____

Play with pets _____ Play with children _____ Talk and/or visit with friends _____ Take regular vacations _____

Drink alcohol _____ Use recreational drugs _____ Take medication _____ Get massages _____ Facials _____

Acupuncture _____ Playing or listening to music _____ Dancing _____ Any other? _____

From the following, items please check the best answer that applies to you ..... We are all different, there is no right or wrong answer. It assists in a stress self-evaluation:

1. Is your everyday life filled mostly by: Problems needing a solution _____
   Challenges needing to be met_____
   A rather predictable routine of events _____
   Not enough things to keep you interested or busy _____
   Unaware _____

2. When you are under pressure or stress, do you usually: Take immediate action _____
   Plan carefully before taking action _____
   Procrastinate _____
   Distract yourself _____

3. Ordinarily, how rapidly do you eat? First one finished _____
   I eat a little faster than average _____
   I eat about the same rate as others _____
   I eat more slowly than most _____
   Unaware _____

4. Has anyone ever told you that you eat too fast? Yes, often _____
   Yes, several _____
   Once or twice _____
   Never _____

5. When you are listening to someone, and they are taking too long to get to the point, do you feel like hurrying them along?
   Frequently _____
   Occasionally _____
   Never _____

6. How often do you put words in their mouth to speed things up? Frequently _____
   Occasionally _____
   Never _____

7. If you tell someone that you will meet them at a specific time, how often do you arrive late? Frequently _____
   Rarely _____
   Never _____

8. Would others consider you to be: Definitely hard driving and competitive _____
   Probably hard driving and competitive _____
   Probably more relaxed and easy going _____
   Definitely more relaxed and easy going _____

9. Today, how would you consider yourself to be: Definitely hard driving and competitive _____
   Probably hard driving and competitive _____
   Probably more relaxed and easy going _____

Definitely more relaxed and easy going _____

10. How would your best friend and/or significant other rate your general level of activity?
    Too slow, in need of more structure and activity _____
    Average, moderately busy _____
    Too active, needing to slow down _____

11. In relation to others around you, would you agree that you have less energy than most?
    Definitely, Yes _____
    Probably, Yes _____
    Probably, No _____
    Definitely, No _____

12. How did you deal with anger when you were younger? Currently?
    Fiery and hard to control _____
    Fiery and hard to control _____
    Strong, but controllable _____
    Strong, but controllable _____
    No problems _____
    No problems _____
    Never got angry _____
    Other _____

13. How often are there deadlines in your work?
    Irregularly _____ Hourly _____ Daily _____ Weekly _____ Monthly _____ Never _____

14. Do you ever set deadlines or quotas for yourself? For others?
    No _____ No _____
    Occasionally _____ Occasionally _____
    Frequently _____ Frequently _____

15. During work, do you keep shifting rapidly between two or more projects in a given day?
    No _____ Yes _____ Varies _____ Emergencies only _____

16. How often do you bring work at home at night?
    Daily _____ Weekends only _____ Once a week _____ More than once a week _____ Rarely _____

17. How often do you go to work when it is officially, Closed?
    Daily _____ Weekends only _____ Once a week _____ More than once a week _____ Rarely _____

18. Do you make yourself written lists of Athings to do@ to help you remember and/or set goals for the day?
    Never _____ Occasionally _____ Frequently _____ Daily _____

19. In a sense of responsibility, I am _____ than average.
    Much more _____ Little more _____ Little less _____ Much less _____ Unaware _____

20. In approaching life, I am _____ than average.
    Much more serious _____ Little more serious _____ Little less serious _____ Much less serious _____

Self-Stress Evaluation Questionnaire

Each scale is composed of a pair of phrases separated by a series of horizontal lines. Each pair has been chosen to represent two kinds of contrasting behavior. Each of us belongs somewhere between the two extremes. Since most of us are neither the most competitive nor the least competitive person we know, please put a check mark where you think you belong between the extremes. This was designed by Dr. Howard Glazer to determine Behavior Management between Type A or B behavior vs cardiac prone dis-eases.

	1	**2**	**3**	**4**	**5**	**6**	**7**	
1. Can leave things unfinished Temporarily	__	__	__	__	__	__	__	Must finish things once started
2. Unhurried about appointments	__	__	__	__	__	__	__	Never late for appointments
3. Not competitive	__	__	__	__	__	__	__	Highly competitive
4. Never in a hurry, even under pressure	__	__	__	__	__	__	__	Always in a hurry
5. Listens well, lets others finish speaking	__	__	__	__	__	__	__	Anticipates others in conversation, interrupts
6. Able to wait calmly	__	__	__	__	__	__	__	Restless or uneasy when waiting
7. Easygoing	__	__	__	__	__	__	__	Always going full speed ahead, hard driving
8. Takes on one thing at a time, focused	__	__	__	__	__	__	__	Tries to take on several things, multi tasked
9. Slow and deliberate in speech	__	__	__	__	__	__	__	Vigorous, animated and forceful in speech
10. Concerned with self-satisfaction	__	__	__	__	__	__	__	Needs recognition by others for a job well done
11. Slow at doing things	__	__	__	__	__	__	__	Fast at doing things
12. Expresses feelings easily	__	__	__	__	__	__	__	Difficulty in expressing feelings
13. Has a large number of interests	__	__	__	__	__	__	__	Has only a few interests outside of work
14. Satisfied with job	__	__	__	__	__	__	__	Ambitious, wants advancements
15. Never sets own deadlines	__	__	__	__	__	__	__	Often sets own deadlines
16. Feels limited responsibility	__	__	__	__	__	__	__	Always feels responsible
17. Never judges in terms of numbers	__	__	__	__	__	__	__	Judges performance in terms of AHow many, How much@
18. Casual about work or projects	__	__	__	__	__	__	__	Takes work or projects very seriously
19. Not very precise	__	__	__	__	__	__	__	Very precise

Is your stress getting better, worse or staying the same? _____ How do you know? _____

_____

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

1. _____

2. _____

3. _____

4. _____

5. _____

Emotional Health and Lifestyle Overview

For our time together to be successful, what do you want to take place over the course of your treatment here? _____

_____

How long do you feel this should take? _____

Do you feel that your pain and/or symptoms that you are experiencing could be purposeful? _____ Please explain your belief system _____

_____

Do you feel that your pain or illness is a reflection of short-term superficial circumstances, injury or longer term, potentially deeper seated challenges? _____

_____

_____

What areas of your lifestyle are likely involved with your condition that you would like to improve upon. Prioritize; with marking #1 as being most important and #2, 3, 4, 5 following as it applies to you:

_____ My level of stress

_____ My level of anxiety

_____ Tendencies to swing into depressions

_____ My creative expression

_____ Feelings / direction with career

_____ Relationship issues

_____ Communication skills

_____ My physical limitations due to pain

_____ My fears due to illness, recovery

_____ My pace of living

_____ My diet and nutrition program

_____ My exercise program

_____ My need for better restful sleep

_____ Unwanted habits

What <u>obstacles</u> could prevent you from changing those lifestyle factors that are undermining your health? _____

_____

_____

List your 3 highest priorities in life, speaking only from your heart. Where does your health and vitality factor in?

1. _____

2. _____

3._____

What have you tried to do to improve your state of health, illness or pain? _____

_____

_____

_____

Rate your current emotional health (circle): excellent good fair poor unstable crisis numb addicted to my emotions

Do you have any serious emotional or mental traumas? _____

Are you currently in psychotherapy? _____ If so, for how long? _____

Do you have a good support network? _____ Who are they? _____

Have you been diagnosed with any of the following (circle)?

Manic Depression Bi Polar Schizophrenia ADD OCD BDD Suicidal Tendencies

Are you experiencing any of the following now (circle)? Mood Swings Nervousness Depression Anxiety Panic Attacks

Is there any history of emotional and/or physical abuse in your life; past or present? Please explain if this is applicable to you _____

_____

_____

What feelings are you experiencing right now (considering only the core ones), please circle:

Joy Anger Sadness Pain Fear Loneliness Guilt Shame Shock

Which feelings to you experience most often? _____ Which feelings would you prefer to avoid?_____

Describe any tension or pain you feel when expressing or suppressing these feelings? _____

_____

Any form of Spiritual practice _____

Level of education completed: High school Bachelors Masters Doctorate Other _____

Are you currently enrolled in any academic and/or creative studies? _____

PHYSICAL ASSESSMENT

What is the purpose of today@s visit? _____

Condition resulted from: Auto accident Fall Injury Sporting accident Work related Chronic Disorder Other _____

Have you seen any other Doctor for this condition? Yes _____ No _____ If yes, when _____

Doctors name, address and telephone _____

Please indicate if you are experiencing any of the following symptoms:

HEAD
___ Headache
___ Entire head
___ Back of head
___ Forehead
___ Temples
___ Migraines
___ Occipital w/ stiff neck
___ Head feels heavy
___ Nasal congestion
___ Loss of memory
___ Light headedness
___ Fainting
___ Light bothers eyes
___ Tired eyes
___ Loss of sight
___ Loss of smell
___ Loss of taste
___ Loss of hearing
___ Loss of balance
___ Dizziness
___ Pain in ears
___ Discharge from ears
___ Ringing in ears
___ Buzzing in ears

NECK
___ Pain without movement
___ Pain with movement
___ Pinched nerve in neck
___ Neck feels out of place
___ Stiffness
___ Muscle spasms
___ Grinding sounds
___ Grating sounds
___ Popping sounds
___ Arthritis

SHOULDERS
___ Pain in shoulder joint (R L)
___ Pain across shoulders
___ Bursitis (R L)
___ Arthritis (R L)
___ Cannot raise arm
___ Tension in shoulders
___ Pinched nerve in shoulder (R L)
___ Muscle spasms

ARMS & HANDS
___ Pain in upper arm (R L)
___ Pain in forearm (R L)
___ Pain in hands (R L)
___ Pain in fingers (R L)
___ Pinched nerve in arm (R L)
___ Pinched nerve in fingers (R L)
___ Pins & needles in arms (R L)
___ Pins & needles in fingers (R L)
___ Fingers go to sleep (R L)
___ Cold hands
___ Swollen joints in fingers (R L)
___ Sore joints in fingers (R L)
___ Arthritis in fingers (R L)
___ Loss of grip strength (R L)

CHEST
___ Chest pain
___ Shortness of breath
___ Pain around ribs
___ Palpitations
___ Heaviness in chest

MID-BACK
___ Pain in mid-back
___ Pain between shoulder blades
___ Muscle spasms

LOW BACK
___ Low back pain
___ Pinched nerve in low back
___ Slipped disc
___ Low back feels out place
___ Muscle spasms
___ Arthritis

Pain is worse when
___ Working
___ Lifting
___ Stooping
___ Standing
___ Sitting
___ Bending
___ Coughing

HIPS, LEGS & FEET
___ Pain in Buttocks (R L)
___ Pain in hip joint (R L)
___ Pain down leg (R L)
___ Pain down both legs
___ Leg cramps
___ Pins & needles in legs
___ Numbness in legs (R L)
___ Numbness in feet (R L)
___ Numbness of toes (R L)
___ Cold feet
___ Cramps in feet
___ Swollen ankles (R L)
___ Swollen feet (R L)
___ Painful joints in toes (R L)
___ Pain in foot (R L)
___ Pain in knees (R L)

Dietary Assessment

1. Have you ever been on a diet? Yes _____ No _____ If yes, please describe the various diets _____
_____

_____

2. Have you taken diet pills? Yes _____ No _____ If yes, please list types of diet pills taken and for how long _____

_____

_____

3. Are you happy with your current weight? Yes _____ No _____ If no, why not? _____

_____

4. Which of the following best describes your meal plans:

High carbs, low fats (Pritikin) _____
High protein, low carbs _____
High carbs, high fats _____
Atkins _____
Vegetarian _____
Mostly snacking on the go _____
Home cooking _____

Lactose intolerant, and food allergies _____
Irregular meals _____
Constant dieting _____
Zone diet _____
Jenny Craig food plan _____
Mainly restaurants _____
Fast foods _____

Please list the last 2 days of meals, snacks and beverages, including the approximate time:

Day 1

Breakfast _____ Lunch _____ Dinner _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Snacks _____ Snacks _____ Snacks _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Day 2

Breakfast _____ Lunch _____ Dinner _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Snacks _____ Snacks _____ Snacks _____
_____ _____ _____
_____ _____ _____
_____ _____ _____