

## Registration Form

Date \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

E-Mail \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
(if you plan on using insurance) (if you plan on using insurance)

Referred By: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ No. children: \_\_\_\_\_

Contact in case of emergency: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If under 18 who is responsible for payment? \_\_\_\_\_

Method of payment: Cash/Check \_\_\_\_\_ Personal Injury \_\_\_\_\_ Insurance \_\_\_\_\_  
Worker's Comp \_\_\_\_\_

### PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for account: \_\_\_\_\_

HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE CARRIER AND THE PATIENT. THESE POLICIES ARE USUALLY DESIGNED TO OFFSET A LARGE PORTION OF THE TOTAL COST OF TREATMENT. THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY TO THE PATIENT. IF SPECIAL CIRCUMSTANCES EXIST PLEASE NOTIFY US IN ADVANCE. IT SHOULD BE UNDERSTOOD THAT ALL SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT WHO IS PERSONALLY RESPONSIBLE FOR PAYMENT.

A FINANCE CHARGE OF 15 % WILL BE ADDED TO ANY UNPAID BALANCE AFTER 30 DAYS. IF AN APPOINTMENT IS MISSED WITHOUT A 24 HOUR NOTICE THERE WILL BE A \$25 MISSED APPOINTMENT FEE

Patient Signature: \_\_\_\_\_

# CONFIDENTIAL CASE HISTORY

Chief complaints due to:  Physical illness  Emotional illness  Injury  Auto accident  
 Lifestyle  Chemical exposure  Work related injury  Pregnancy or childbirth

Other \_\_\_\_\_

List symptoms briefly in order of importance:

1. \_\_\_\_\_ Since \_\_\_\_\_
2. \_\_\_\_\_ Since \_\_\_\_\_
3. \_\_\_\_\_ Since \_\_\_\_\_
4. \_\_\_\_\_ Since \_\_\_\_\_
5. \_\_\_\_\_ Since \_\_\_\_\_
6. \_\_\_\_\_ Since \_\_\_\_\_

What makes your symptoms better/worse:

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

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

What time of day are the symptoms worse?

Morning  Afternoon  Evening  During the night  Symptom(s) is/are constant

Are you currently being treated for your condition(s) by another doctor or doctor(s)  Yes  No

	Doctor's name	Type of doctor	Approx. date started care
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please check health care providers you have had in the past:

Chiropractor  Homeopath  Acupuncturist  Dentist  Nutritionist

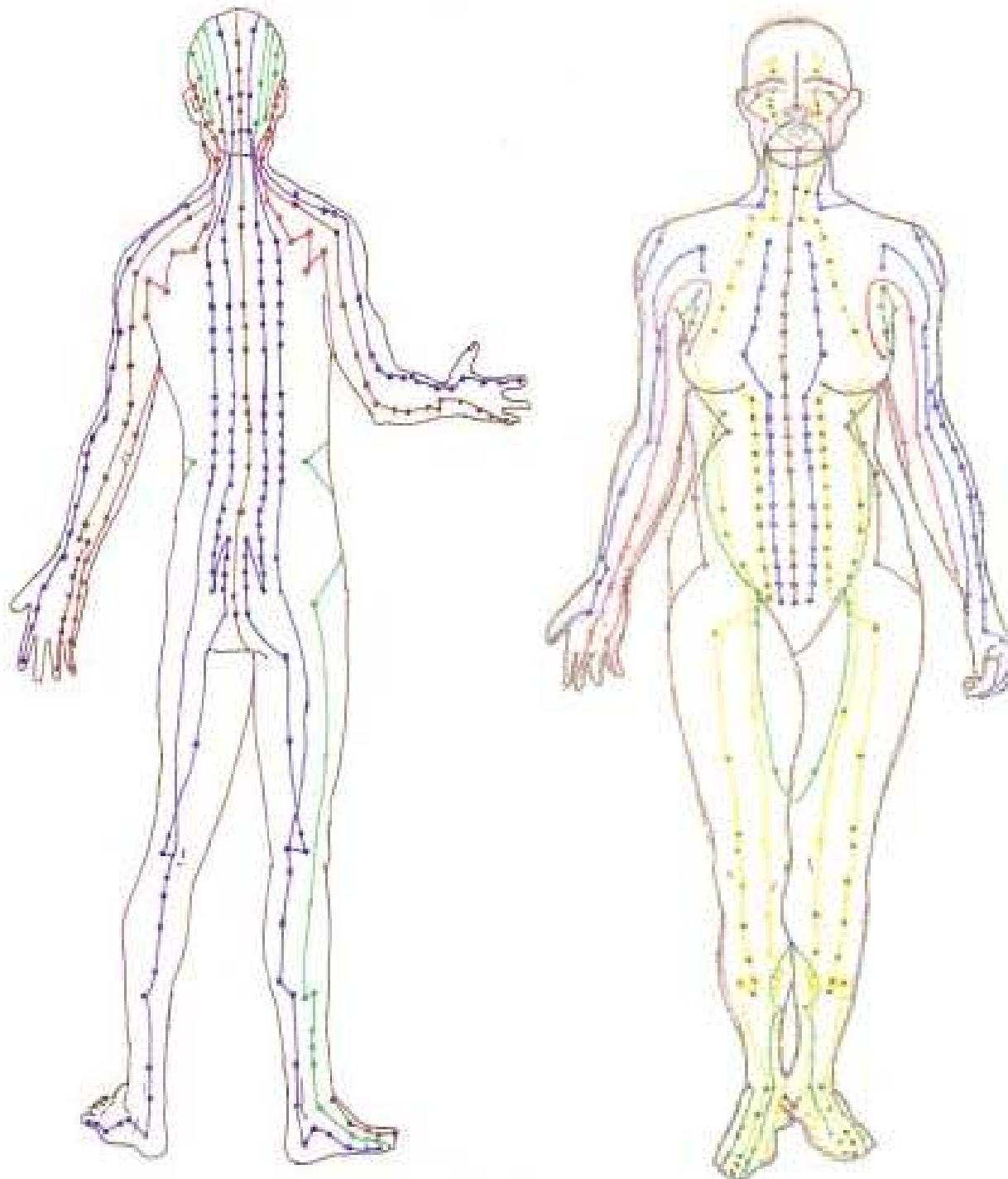
Physical therapist  Osteopath  Medical doctor

- You may print the form in black and white or color

Using the symbols given below, circle or mark the areas of your body where you feel the described **pain or sensations of any kind**. Included all affected areas.

Aching ? ? ?	Numbness = = =	Pins and Needles ? ? ?	Burning X X X	Stabbing / / /	Other ? ? ?
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For the purposes of this form we know that the front is a picture of a woman and the back is a picture of a man.. Think of this as gender neutral. If you are a man and the pain is in the chest, mark the chest area. Don't be concerned with the lines. They show energy flows in the body, this will help during the consultation.



# Holistic Health Solutions **HEALTH ASSESSMENT**

**Circle any of the following medications are you taking:**

- |                       |                               |                    |                          |
|-----------------------|-------------------------------|--------------------|--------------------------|
| Antacids              | Chemotherapy                  | Hormones           | Relaxants/Sleeping Pills |
| Antibiotic/Antifungal | Cortisone Anti-Inflammatories | Laxatives          | Recreational Drugs       |
| Antidepressants       | Diuretics                     | Lithium            | Specify _____            |
| Antidiabetic/Insulin  | Heart Medications             | Oral Contraceptive | Thyroid                  |
| Aspirin/Tylenol       | High Blood Pressure           | Radiation          | Ulcer Medications        |

Other \_\_\_\_\_

These questions help to evaluate energetic stress so that supportive therapy or nutrition can be given, they do not show the presence nor absence of disease.

**List Vitamins and non-drug supplements you are taking:**

List vitamins, minerals, herbs, homeopathics, etc. currently taken, including ascorbic acid, garlic, herbal laxatives, etc. \_\_\_\_\_

**Circle if you eat, drink, or use:**

- |                     |  |                |                     |
|---------------------|--|----------------|---------------------|
| Alcohol             | Distilled Water                        | Luncheon Meats | Non-Herbal Teas     |
| Candy               | Fluoridated/Chlorinated Water          | Margarine      | Chew Tobacco        |
| Carbonated Beverage | Eat at fast food restaurants regularly | Refined Sugars | Vitamins & Minerals |
| Cigarettes          | Fried Foods                            | Milk Products  | Specify _____       |
| Coffee              | Refined (White) Flour Products         |                | Artificial Sweetner |

Approximately how much water do you drink a day? \_\_\_\_\_

**Circle if you:**

- Diet often                      Exercise Less than 3 times weekly                      Are exposed to chemicals at work

**What is your blood type?**    \_\_\_Type A            \_\_\_Type B            \_\_\_Type AB            \_\_\_Type O            \_\_\_Not Sure

**Directions:**                      **Please read each description and click on the number, which best describes the frequency of your symptoms within the past year.**

**Key:**    **0 = Never**                      **1 = Mild**                      **2 = Moderate**                      **3 = Severe**

(Occurs once a month or less)                      (Occurs several times monthly)                      (Aware of it almost constantly)

**Category 1**

**Section A: Stomach Digestion Stress**

1. Bad Breath, halitosis..... 0 1 2 3

2. Loss of taste for high protein foods (meat, etc.) ..... 0 1 2 3

3. Burning (acid) or nervous stomach, eating relieves ..... 0 1 2 3

4. Gas shortly after eating ..... 0 1 2 3

5. Indigestion 1/2 to 1 hour after eating, may last 3-4 hours..... 0 1 2 3

6. Difficulty digesting fruits or vegetables; undigested foods found in stools ..... 0 1 2 3

7. Acid or spicy foods upset stomach..... 0 1 2 3

**Section C: Intestinal Stress (Continued)**

28. Bowel movements painful or difficult, constipation, and/or laxatives used ..... 0 1 2 3

29. Burning or itching anus ..... 0 1 2 3

**Section B: Liver, Gallbladder Stress**

8. Lower bowel gas and or bloating several hours after eating..... 0 1 2 3

9. Feet burn ..... 0 1 2 3

10. "Whites" of eyes (sclera) yellow ..... 0 1 2 3

11. Dry skin, itchy feet and /or skin peels on feet..... 0 1 2 3

12. Brown spots or bronzing of skin..... 0 1 2 3

13. Bitter metallic taste in mouth..... 0 1 2 3

14. Blurred vision ..... 0 1 2 3

15. Headache over eyes ..... 0 1 2 3

16. Feel nauseous, queasy or gag easily ..... 0 1 2 3

17. Color of stools light brown or yellow..... 0 1 2 3

18. Greasy or high fat foods cause distress..... 0 1 2 3

19. Pain between shoulder blades..... 0 1 2 3

20. Dark circles under eyes..... 0 1 2 3

21. "Acid"breath..... 0 1 2 3

22. History of gallbladder attacks or gallstones..... 0 1 2 3

OR gallbladder removed..... YES NO

23. Appetite reduced..... 0 1 2 3

**Category 2: Allergic Stress**

30. Head congestion/sinus fullness ..... 0 1 2 3

31. Sneezing attacks ..... 0 1 2 3

32. Dreaming, nightmare-like bad dreams..... 0 1 2 3

33. Milk products and/or wheat products cause distress ..... 0 1 2 3

34. Eyes and nose watery ..... 0 1 2 3

35. Eyes swollen and puffy..... 0 1 2 3

36. Pulse speeds after meals and/or heart pounds after retiring..... 0 1 2 3

**Category 3:**

**Section: A Blood Sugar Stress**

37. Crave sweets or coffee in afternoon or mid-morning..... 0 1 2 3

38. Hungry between meals or excessive appetite..... 0 1 2 3

39. Overeating sweets upsets ..... 0 1 2 3

40. Eat when nervous ..... 0 1 2 3

41. Irritable before meals ..... 0 1 2 3

42. Get "shaky" or light-headed if meals delays ..... 0 1 2 3

43. Fatigue, eating relieves ..... 0 1 2 3

44. Heart palpitates if meals missed or delayed..... 0 1 2 3

45. Awaken a few hours after sleep, hard to get back to sleep..... 0 1 2 3

**Section C: Intestinal Stress**

24. Coated tongue or "fuzzy" debris on tongue..... 0 1 2 3

25. Pass large amounts of foul smelling gas..... 0 1 2 3

26. Irritable bowel or mucous colitis..... 0 1 2 3

27. Constipation, diarrhea alternating or stools alternate from soft to watery ..... 0 1 2 3

**Section: B Vitamin Deficiency**

46. Muscle soreness after moderate exercise..... 0 1 2 3

47. Vulnerability to insect bites (especially fleas and mosquitoes..... 0 1 2 3

48. Loss of muscle tone or "heaviness" in arms or legs..... 0 1 2 3

49. Enlarged heart and/or heart failure ..... 0 1 2 3

50. Worried, feel insecure and/or highly emotional..... 0 1 2 3

51. Pulse slow/below 65 or irregular pulse ..... YES NO

**Category 4:**  
**Section: A Pituitary Hormone Stress**

52. Sex drive increased.....	0	1	2	3
53. "Splitting" type headaches .....	0	1	2	3
54. Memory failing .....	0	1	2	3
55. Tolerance for sugar reduced .....	0	1	2	3

**Section: B Pituitary Hormone Fatigue Stress**

56. Sex drive reduced or absent .....	0	1	2	3
57. Abnormal thirst .....	0	1	2	3
58. Weight gain around hips or waist .....	0	1	2	3
59. Tendency to ulcers or colitis .....	0	1	2	3
60. Increased ability to eat sugar without symptoms .....	0	1	2	3
61. Menstrual disorders (women) .....	0	1	2	3
62. Lack of menstruation (young girls).....	0	1	2	3

**Section: C Thyroid Stress1**

63. Difficulty gaining weight, even if large appetite .....	0	1	2	3
64. Heart palpitations .....	0	1	2	3
65. Nervous, emotional, and/or can't work under pressure.....	0	1	2	3
66. Insomnia .....	0	1	2	3
67. Inward trembling.....	0	1	2	3
68. Night sweats .....	0	1	2	3
69. Fast pulse at rest .....	0	1	2	3
70. Intolerant to high temperatures .....	0	1	2	3
71. Easily flushed .....	0	1	2	3

**Section: D Thyroid Fatigue Stress**

72. Difficulty losing weight .....	0	1	2	3
73. Reduced initiative and/or mental sluggishness .....	0	1	2	3
74. Easily fatigued, sleepy during the day .....	0	1	2	3
75. Sensitive to cold, poor circulation (cold hands and feet)....	0	1	2	3
76. Dry or scaly skin .....	0	1	2	3
77. "Ringing" in ears/noises in head .....	0	1	2	3
78. Hearing impaired .....	0	1	2	3
79. Constipation .....	0	1	2	3
80. Excessive falling hair and/or course hair.....	0	1	2	3
81. Headaches when awaken/wear off during day .....	0	1	2	3

**Section: E Adrenal Stress**

82. Blood pressure increased .....	0	1	2	3
83. Headaches .....	0	1	2	3
84. Hot flashes .....	0	1	2	3
85. Hair growth on face or body (women).....	0	1	2	3
86. Masculine tendencies (women) .....	0	1	2	3

**Section: F Adrenal Fatigue Stress**

87. Blood pressure low .....	0	1	2	3
88. Crave salt .....	0	1	2	3
89. Chronic fatigue/get drowsy .....	0	1	2	3
90. Afternoon yawning .....	0	1	2	3
91. Weakness/dizziness .....	0	1	2	3
92. Weakness after colds/slow recovery .....	0	1	2	3
93. Circulation poor .....	0	1	2	3
94. Muscular and nervous exhaustion .....	0	1	2	3
95. Subject to colds, asthma, bronchitis (respiratory disorders).....	0	1	2	3
96. Allergies and/or hives .....	0	1	2	3
97. Difficulty maintaining manipulative correction.....	0	1	2	3
98. Arthritic tendencies .....	0	1	2	3
99. Nails weak, ridged .....	0	1	2	3
100. Perspire easily .....	0	1	2	3
101. Slow starter in morning .....	0	1	2	3
102. Afternoon headaches .....	0	1	2	3

**Category 5**  
**Section A: Mineral depletion**

103. Frequent skin rashes and/or hives .....	0	1	2	3
104. Muscle-leg-toe cramping at rest and/or while sleeping .....	0	1	2	3
105. Fever easily raised/fevers common .....	0	1	2	3
106. Crave chocolate .....	0	1	2	3
107. Feet have bad odor .....	0	1	2	3
108. Hoarseness frequent.....	0	1	2	3
109. Difficulty swallowing .....	0	1	2	3
110. Joint stiffness after rising .....	0	1	2	3
111. Vomiting frequent .....	0	1	2	3
112. Tendency to anemia.....	0	1	2	3
113. "Whites" of eyes (sclera) blue.....	0	1	2	3
114. "Lump" in throat.....	0	1	2	3
115. Dry mouth-eyes-nose .....	0	1	2	3
116. White spots on finger nails.....	0	1	2	3
117. Cuts heal slowly and/or scar easily .....	0	1	2	3
118. Reduced or "lost" sense of taste and/or smell.....	0	1	2	3
119. Susceptible to colds, fevers, and/or infections.....	0	1	2	3
120. Strong light irritates eyes.....	0	1	2	3
121. Noises in head or ringing in ears .....	0	1	2	3
122. Burning sensations in mouth.....	0	1	2	3
123. Numbness in hands and feet (extremities "go to sleep") .....	0	1	2	3
124. Intolerant to monosodium glutamate (MSG).....	YES	NO		
125. Cannot recall dreams.....	0	1	2	3
126. Nose bleeds frequent.....	0	1	2	3
127. Bruise easily, "black and blue" spots.....	0	1	2	3
128. Muscle cramps, worse with exercise ("charley horses")...	0	1	2	3

**Category 6**  
**Cardio Vascular Stress**

129. Aware of heavy and/or irregular breathing.....	0	1	2	3
130. Discomfort in high altitudes .....	0	1	2	3
131. "Air hunger"/ sigh frequently .....	0	1	2	3
132. Swollen ankles/worse at night .....	0	1	2	3
133. Shortness of breath with exertion .....	0	1	2	3
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion .....	0	1	2	3

**Category 7 Female Only**  
**Female Hormone Stress**

135. Premenstrual tension .....	0	1	2	3
136. Painful menses (cramping, etc.).....	0	1	2	3
137. Menstruation excessive or prolonged .....	0	1	2	3
138. Painful/tender breasts .....	0	1	2	3
139. Menstruate too frequently .....	0	1	2	3
140. Acne, worse at menses.....	0	1	2	3
141. Depressed feelings before menstruation.....	0	1	2	3
142. Vaginal discharge .....	0	1	2	3
143. Menses scanty or missed .....	0	1	2	3
144. Hysterectomy/ovaries removed .....	YES	NO		
145. Menopausal hot flashes.....	0	1	2	3
146. Depression .....				

**Category 8 Men Only**  
**Male Hormone Stress**

147. Prostate trouble .....	0	1	2	3
148. Urination difficult or dribbling.....	0	1	2	3
149. Night urination frequent .....	0	1	2	3
150. Pain on inside of legs or heels .....	0	1	2	3
151. Feeling of incomplete bowel evacuation .....	0	1	2	3
152. Leg nervousness at night .....	0	1	2	3
153. Tire easily/avoid activity .....	0	1	2	3
154. Reduced sex drive .....	0	1	2	3
155. Depression .....	0	1	2	3
156. Migrating aches and pains .....	0	1	2	3

## MENTAL STRESS

Have you ever been to a psychologist? \_\_\_\_\_ Yes \_\_\_\_\_ No

For what purpose?

1. \_\_\_\_\_ Date \_\_\_\_\_

2. \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been to a psychiatrist? Yes No

\_\_\_\_\_ In the past \_\_\_\_\_ Currently

Type of treatment rendered:

\_\_\_\_\_ Talking only \_\_\_\_\_ Drugs prescribed \_\_\_\_\_ Hypnosis \_\_\_\_\_ Electric shock  
\_\_\_\_\_ Brain surgery

## DENTAL SURVEY

Tooth decay: \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ None

Gum disease: \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ None

Do you have silver/mercury fillings? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain

How many root canals have you had? \_\_\_\_\_

Last dental visit \_\_\_\_\_ What was done? \_\_\_\_\_

Ever had braces or other dental appliance? If yes, please describe: \_\_\_\_\_

## Drugs

\_\_\_\_\_ I have used recreational drugs in the past: \_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_ Frequently  
\_\_\_\_\_ Heavily

Recreational drugs used in the past: \_\_\_\_\_ Marijuana/Hashish \_\_\_\_\_ Barbiturates (downers)

\_\_\_\_\_ Sleeping pills \_\_\_\_\_ Speed \_\_\_\_\_ Cocaine \_\_\_\_\_ LSD

Other: \_\_\_\_\_

**CHEMICAL EXPOSURE**

What is your current occupation? \_\_\_\_\_

List all chemicals you currently come in contact with: \_\_\_\_\_

\_\_\_\_\_

How often are you required to work with the above mentioned substances?

\_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_ Daily

Chemical exposure in the past:

\_\_\_\_\_ Pesticides \_\_\_\_\_ Automotive \_\_\_\_\_ Solvents \_\_\_\_\_ Poisons \_\_\_\_\_ Accidental

Other \_\_\_\_\_

Briefly describe, include length of exposure:

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

\_\_\_\_\_ Food allergies. Describe: \_\_\_\_\_

\_\_\_\_\_ Drug allergies. Describe: \_\_\_\_\_

\_\_\_\_\_ Pollens \_\_\_\_\_ Dust \_\_\_\_\_ Cat hair \_\_\_\_\_ Dog hair \_\_\_\_\_ Grasses

Other: \_\_\_\_\_

**SURGERIES**

Check any surgeries/operations you have had and the approximate date:

\_\_\_\_\_ Tonsillectomy \_\_\_\_\_ Appendectomy \_\_\_\_\_ Gall bladder removed

\_\_\_\_\_ Heart surgery

\_\_\_\_\_ Orthopedic surgery \_\_\_\_\_ Metal implants. Describe: \_\_\_\_\_

\_\_\_\_\_ Cosmetic surgery Describe: \_\_\_\_\_

\_\_\_\_\_ Complete hysterectomy (Uterus/Both ovaries) \_\_\_\_\_ Uterus only \_\_\_\_\_ Uterus and one ovary

\_\_\_\_\_ Spinal surgeries

1. \_\_\_\_\_ Date \_\_\_\_\_

2. \_\_\_\_\_ Date \_\_\_\_\_

3. \_\_\_\_\_ Date \_\_\_\_\_

## HOSPITALIZATIONS

List all hospitalizations and approximate dates (no need to include surgeries listed above):

1. \_\_\_\_\_ 2. \_\_\_\_\_
3. \_\_\_\_\_ 4. \_\_\_\_\_
5. \_\_\_\_\_ 6. \_\_\_\_\_

## PAST MEDICAL HISTORY

Please list all health problems you have had in the past. That includes birth defects, all childhood illnesses, any diagnosed diseases, high fevers or recurring infections and the approximate dates. If the name of the disease is not known, briefly describe the symptoms. Include severity, medicine taken or any other important details. Use back of page if needed.

Prenatal/Birth (if known): \_\_\_\_\_

Newborn: \_\_\_\_\_

Childhood: \_\_\_\_\_

Adolescence: \_\_\_\_\_

Adult: \_\_\_\_\_

Have you ever been diagnosed with any of the following? Include the approximate date of first occurrence.

\_\_\_\_\_ Mono/Epstein Barr virus      Date: \_\_\_\_\_

\_\_\_\_\_ Herpes: oral    genital      Date: \_\_\_\_\_

\_\_\_\_\_ Canker sores                      Date: \_\_\_\_\_

\_\_\_\_\_ Scarlet fever                      Date: \_\_\_\_\_

\_\_\_\_\_ Rheumatic fever                      Date: \_\_\_\_\_

\_\_\_\_\_ Bladder infections                      Date: \_\_\_\_\_

\_\_\_\_\_ Kidney infections                      Date: \_\_\_\_\_

\_\_\_\_\_ Hepatitis (liver inflammation) \_\_\_\_\_

Which type?    \_\_\_\_\_ Hepatitis A    \_\_\_\_\_ Hepatitis B    \_\_\_\_\_ Hepatitis C    \_\_\_\_\_ Other    \_\_\_\_\_ Not sure



**ACCIDENT HISTORY**

Include date and brief description.

\_\_\_\_\_ Broken bones: \_\_\_\_\_

\_\_\_\_\_ Motor vehicles: \_\_\_\_\_

\_\_\_\_\_ Head trauma: \_\_\_\_\_

\_\_\_\_\_ Other injuries: \_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATION RECORD**

\_\_\_\_\_ Usual childhood immunizations      \_\_\_\_\_ Partial immunization      \_\_\_\_\_ Never been immunized

\_\_\_\_\_ Immunizations for overseas travel

List the type of vaccines and approximate number of times: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FOR FEMALES ONLY

### BIRTH CONTROL:

I.U. D.  Currently use  Used in the past from \_\_\_\_\_ to \_\_\_\_\_  
 Birth control pills  Currently use  Used in the past from \_\_\_\_\_ to \_\_\_\_\_  
 Barrier method Type: \_\_\_\_\_  
 Other: \_\_\_\_\_

### MENSTRUAL CYCLE

Regular periods Last period \_\_\_\_\_  
 Irregular periods. Since: \_\_\_\_\_ Describe: \_\_\_\_\_  
 No periods. Since: \_\_\_\_\_ Describe: \_\_\_\_\_

### MENSTRUAL SYMPTOMS:

Cramps  Back pain  Breast soreness  
 Normal flow  Light flow  Heavy flow  Sometimes hemorrhage

Are the symptoms:  Mild  Moderate  Severe

Other difficulties (mood swings, food cravings, etc.): \_\_\_\_\_

### CHILDBIRTH HISTORY

Number of pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

Did you have any difficulties during pregnancy?

Please describe; \_\_\_\_\_

Did you have any difficulties during labor and delivery? Please describe: \_\_\_\_\_

### VAGINAL DISCHARGE

Chronic  Have had in the past(not currently a problem)  Yeast/Candida  Bacterial  
 Not sure

What treatment was given? \_\_\_\_\_ Not sure

### FIBROUS CYSTS:

Breasts  Uterus  Ovaries  Other \_\_\_\_\_

Please describe: \_\_\_\_\_

### SEXUALLY TRANSMITTED DISEASES (Include date diagnosed)

Chlamydia Date: \_\_\_\_\_  Trichomonas Date: \_\_\_\_\_  Gonorrhea Date: \_\_\_\_\_

Syphilis Date: \_\_\_\_\_  Genital herpes Date: \_\_\_\_\_  Oral herpes Date: \_\_\_\_\_

Genital warts Date: \_\_\_\_\_  Other: \_\_\_\_\_

Not sure  Never had

**MALE ONLY**

URINARY TRACT:

\_\_\_\_\_ Urination slow to start                      \_\_\_\_\_ Stream too small                      \_\_\_\_\_ Dribbling  
\_\_\_\_\_ Frequent night urination                      \_\_\_\_\_ Bladder pain after urination  
\_\_\_\_\_ Pain or pressure after sexual relations                      \_\_\_\_\_ Burning                      \_\_\_\_\_ Discharge

SEX DRIVE:

\_\_\_\_\_ Excessive                      \_\_\_\_\_ Diminished                      \_\_\_\_\_ Absent                      \_\_\_\_\_ Normal  
\_\_\_\_\_ Overly tired and exhausted                      \_\_\_\_\_ Impotency

DO YOU HAVE ANY OF THE FOLLOWING:

\_\_\_\_\_ Testicle pain                      \_\_\_\_\_ Hernia                      \_\_\_\_\_ No difficulties at all

Other: \_\_\_\_\_

SEXUALLY TRANSMITTED DISEASES: (Include approximate date diagnosed)

\_\_\_\_\_ Non-specific urethritis Date: \_\_\_\_\_                      \_\_\_\_\_ Chlamydia Date \_\_\_\_\_  
\_\_\_\_\_ Trichomonas Date: \_\_\_\_\_                      \_\_\_\_\_ Gonorrhea Date: \_\_\_\_\_  
\_\_\_\_\_ Syphilis Date: \_\_\_\_\_                      \_\_\_\_\_ Genital warts Date: \_\_\_\_\_  
\_\_\_\_\_ Genital herpes Date: \_\_\_\_\_                      \_\_\_\_\_ Oral herpes Date: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_ Not sure                      \_\_\_\_\_ Never had