

# 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.

## 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 commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

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 support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing any lifestyle factors which may be undermining your health or adhering to the therapeutic protocols we will be sharing with you?

What do you love to do?

Rate your level of fulfillment in the following areas of your life. 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
Relationship	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 problems? List as many as you can in order of importance:

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_
- (5) \_\_\_\_\_
- (6) \_\_\_\_\_
- (7) \_\_\_\_\_

Do you have any known contagious diseases at this time? Y N

If yes, what? \_\_\_\_\_

### 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 to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

Any chemicals? \_\_\_\_\_

## CURRENT 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: \_\_\_\_\_

Do you strongly desire any particular foods? \_\_\_\_\_

Do you strongly dislike any particular foods? \_\_\_\_\_

Are there any foods which make you feel bad or aggravate any of your symptoms? \_\_\_\_\_

## 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? _____		Read? _____		Y	N
Do you exercise?	Y	N	How many hours? _____	Y	N
If yes, what kind? _____			Do you use alcoholic beverages?	Y	N
Have a supportive relationship?	Y	N	Treated for alcoholism?	Y	N
Have a history of abuse?	Y	N	Do you use tobacco?	Y	N
Any major traumas?	Y	N	Smoked previously?	Y	N
Use recreational drugs?	Y	N	How many years? _____	Y	N
Been treated for drug dependence?	Y	N	How many packs per day? _____		
Enjoy your work?	Y	N	Religious or spiritual practice?	Y	N
Spend time outside?	Y	N	Take vacations?	Y	N
Watch television?	Y	N			
How many hours? _____					

## 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

	<b>ENDOCRINE</b>						
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
	<b>IMMUNE</b>						
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
	<b>NEUROLOGIC</b>						
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
	<b>SKIN</b>						
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
	<b>HEAD</b>						
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
	<b>FACE</b>						
Pain/neuralgia?	Y	N	P	Excessive sweating	Y	N	P
Acne?	Y	N	P	Discoloration?	Y	N	P
Twitching?	Y	N	P				
	<b>EYES</b>						
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
	<b>EARS</b>						
Impaired hearing?	Y	N	P	Ringings/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
	<b>NOSE AND SINUSES</b>						
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

## 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?			

### 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

### SLEEP

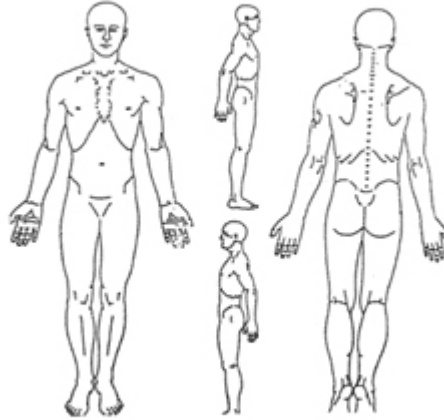
Difficulty falling asleep?	Y	N	P	Favorite sleep position? _____			
Jerking on falling asleep?	Y	N	P	Stay covered during the night?	Y	N	
Interrupted sleep?	Y	N	P	Stick feet out of covers?	Y	N	
Sleep walking?	Y	N	P	Wear socks to bed?	Y	N	
Talking in sleep?	Y	N	P	Feeling on waking in morning? _____			
Grinding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

# PAIN

Mark areas of discomfort or pain:



When did the pain/s start? \_\_\_\_\_

How did the pain/s start? Was it due to injury? \_\_\_\_\_

Describe the quality of the pain/s pain: \_\_\_\_\_

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? \_\_\_\_\_

Does the pain interfere with any daily activities? \_\_\_\_\_

**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.**