Glow Natural Health
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General Information

Wellness goals – check those that you are interested in:

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Eliminate pain
- ☐ Emotional well-being
- ☐ Fertility
- ☐ Hormone balancing
- ☐ Improved basic health
- ☐ Improved energy
- ☐ Improved fitness
- ☐ Improved sleep
- ☐ Lab tests
- ☐ Orthotics
- ☐ Prevent chronic disease
- ☐ Primary care
- ☐ Psychotherapy
- ☐ Reduce drug side effects
- ☐ Shamanic Healing
- ☐ Stress reduction
- ☐ Supplements for health
- ☐ Supportive cancer care
- ☐ Therapeutic massage
- ☐ Weight loss

Current Complaint

Main problem(s) you'd like help with._____
_____
How long ago did this problem begin (month/day /year)?_____
Does this problem interfere with your daily activities (work, sleep, sex)?_____
Problem gets worse with…_____
Problem gets better with…_____
Have you ever been given a diagnosis for this problem?_____
What kinds of treatment have you tried?_____

Past History

Hospitalizations_____
_____
Significant illnesses_____
_____
Significant traumas or injuries_____
_____
Date of last physical exam _____

Please check any condition that applies to you or a family member and include the date(s). (Self=S, Family=F)

	S	F		S	F
Addiction issues	☐	☐	Asthma	☐	☐
Allergies	☐	☐	Gout	☐	☐
Alzheimer's	☐	☐	Cancer	☐	☐
Anemia	☐	☐	What type?_____		
Arthritis	☐	☐			

	S	F		S	F

Depression/ Anxiety	☐	☐	High blood pressure	☐	☐
Diabetes	☐	☐	High cholesterol	☐	☐
Edema	☐	☐	HIV	☐	☐
Eczema	☐	☐	Kidney disease	☐	☐
Epilepsy	☐	☐	Mental illness	☐	☐
Headaches	☐	☐	Osteoporosis	☐	☐
Heart attack/disease	☐	☐	Stroke	☐	☐
Hepatitis	☐	☐	Thyroid disease	☐	☐
Herpes	☐	☐	Tuberculosis	☐	☐

Habits

Alcohol (per week) _____
Coffee/tea/ cola (per week) _____
Soft drinks (per week) _____
Tobacco (packs per day) _____
Drugs (for non medical purposes) _____
Sleep (hours per night) _____
Water (per day) _____

Have you ever been on a restricted diet? Y/ N What kind?_____

Average daily diet:

Morning Afternoon Evening

_____

_____

Do you crave sugar or salty foods? Y/ N Which? _____

Do you have a regular exercise program? Y/ N If yes, please describe:_____

_____

Do you have a spiritual practice? Y/ N If yes, please describe:_____

_____

Do you have allergies? (food, environmental, drug?) If yes, please list:_____

_____

Please list prescription and over the counter medications you are taking.

Medication Dose Date started Prescribed by

_____

_____

_____

_____

Please list vitamins, minerals, herbs, and homeopathic remedies you are taking.

Supplement Dose Date started

_____

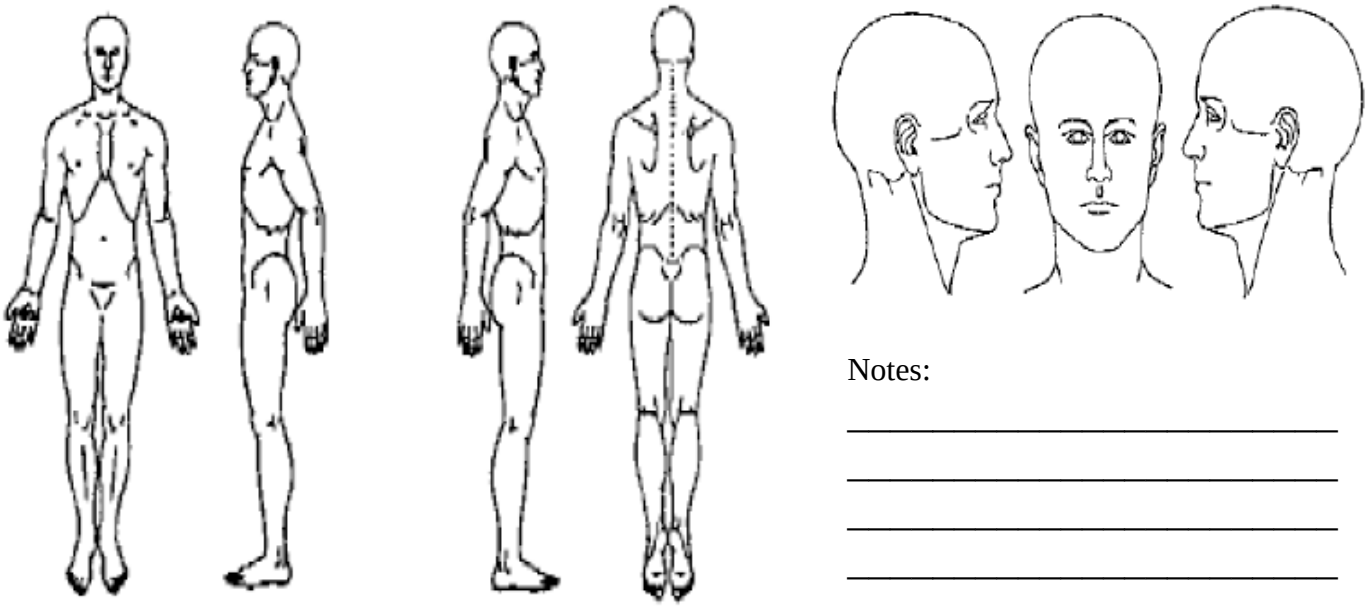
_____

_____

Please indicate painful or distressed areas:

Patient Name: _____Date:_____

Pain level (please mark with an X): No pain_____Worst possible pain



Notes:

_____

_____

_____

_____

_____

Review of Systems

Please check following: N=condition you have now, P=condition you've had in the past

	N	P
Skin		
Dry	☐	☐
Oily	☐	☐
Itching	☐	☐
Rashes	☐	☐
Hives	☐	☐
Fungal Infection	☐	☐
Bruise easily	☐	☐
Slow healing	☐	☐
Warts	☐	☐
Nails Soft ☐ Break ☐		
Head		
Headaches	☐	☐
Migranes	☐	☐
TMJ/jaw pain	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Tremors/Seizures	☐	☐
Eyes		
Vision disturbance	☐	☐
Dryness	☐	☐
Tearing	☐	☐
Pain	☐	☐
Styes	☐	☐
Sensitive to light	☐	☐

	N	P
Ears		
Discharge	☐	☐
Itch	☐	☐
Pain	☐	☐
Ringing	☐	☐
Poor hearing	☐	☐
Nose		
Allergies	☐	☐
Discharge	☐	☐
Color: Clear__ Yellow __ Green __		
Texture: Thin __ Thick __		
Post Nasal Drip	☐	☐
Stuffiness	☐	☐
Sneezing	☐	☐
Infections	☐	☐
Nosebleeds	☐	☐
Frequent colds	☐	☐
Throat/Neck		
Sore throat	☐	☐
Swollen Glands	☐	☐
Difficulty swallowing	☐	☐

	N	P
Mouth		
Dryness	☐	☐
Canker sores	☐	☐
Bleeding gums	☐	☐
Respiratory		
Pneumonia	☐	☐
Bronchitis	☐	☐
Cough	☐	☐
Asthma	☐	☐
Shortness of breath	☐	☐
Coughing up blood	☐	☐
Cardiovascular		
Chest pain	☐	☐
Heart racing/pounding	☐	☐
Heart Disease	☐	☐
Murmur	☐	☐
Blood Pressure High__ Low __		
Cholesterol High__ Low __		
Leg Pain__ Cramps __		
Ankle swelling	☐	☐
Cold Hands__ Feet __		

Digestion

Bowel Movement

X per day:

1-2__2-3__3-4__4+ __

X per week:

1-2__2-3__3-4__4+ __

Texture:

Dry__Hard__Loose __

Formed__ Firm ___

Stools with

Mucus __ Blood __

Hemorrhoids ☐ ☐

Fissures/Fistula ☐ ☐

Stool incontinence ☐ ☐

Liver/ gallbladder disease ☐ ☐

Ulcer ☐ ☐

Heartburn ☐ ☐

Bloating ☐ ☐

Belching ☐ ☐

Gas ☐ ☐

Nausea ☐ ☐

Pain/cramps ☐ ☐

Urinary

Difficult urination ☐ ☐

Painful urination ☐ ☐

Incontinence/dribbling ☐ ☐

Blood in urine ☐ ☐

Cloudy urine ☐ ☐

Frequent urination

Day__ Night__

Bladder infections ☐ ☐

Muscular/Skeletal

Back Pain

Low ☐ Mid ☐ Neck ☐

Pain in muscles ☐ ☐

Pain in joints ☐ ☐

Stiffness/ Swelling ☐ ☐

Muscle weakness ☐ ☐

Numbness/Tingling ☐ ☐

Shooting pain ☐ ☐

Paralysis ☐ ☐

Broken bones ☐ ☐

Which?_____

_____

Sprained joints ☐ ☐

Which?_____

_____

Foot pain ☐ ☐

Energy (Scale of 1-10)

1=worst, 10=best _____

Sleep

How many hours? _____

Wake easily? Y / N

Hard to fall asleep? Y / N

Wake rested? Y / N

Snore? Y / N

Grind teeth Y / N

Dreams? Y / N

Temperature

Sensitive to: hot__cold__

Prefer: inside__ outside__

Perspiration

Sweat easily ☐ ☐

Night sweats ☐ ☐

Appetite: excessive __ good__ poor__

Prefer foods: hot__ cold __

Prefer drinks: hot __ cold__

Thirst: excessive__ none__

Recent weight change:_____

Mental/Emotional

Anxiety ☐ ☐

Stress (scale of 1-10 1=none,10=max) _____

Depression ☐ ☐

Suicidal thoughts ☐ ☐

Men Only

Date of last prostate exam:___

Prostate enlargement ☐ ☐

Change in force of urine stream? ☐ ☐

Dribbling ☐ ☐

Difficulty starting and stopping urination? ☐ ☐

Pain in scrotum ☐ ☐

Painful intercourse ☐ ☐

Difficult erections ☐ ☐

Change in sex drive ☐ ☐

STD ☐ ☐

Which?_____

_____

Sexual abuse ☐ ☐

Fertility issues ☐ ☐

Discharge from penis ☐ ☐

Women Only

Date of last pelvic exam:_____

Abnormal pap smear ☐ ☐

STD ☐ ☐

Which?_____

_____

Sexual abuse ☐ ☐

Yeast infections ☐ ☐

Vaginal discharge ☐ ☐

Age of first period _____

Irregular periods ☐ ☐

Flow: heavy__ medium__ light__

Length of cycle _____

Days of flow _____

Date of last period _____

Spotting ☐ ☐

Cramps ☐ ☐

PMS ☐ Endometriosis ☐

Cysts ☐ Fibroids ☐

Have you ever used birth control pills

How long?_____

When? _____

Present birth control method?_____

Change in sex drive ☐ ☐

Painful intercourse ☐ ☐

Pregnancies (#) _____

Children (#) _____

Complications ☐ ☐

Miscarriages (#) _____

Abortions (#) _____

Fertility issues ☐ ☐

Hysterectomy ☐ ☐

Age at menopause ☐ ☐

Vaginal dryness ☐ ☐

Hot flashes ☐ ☐

Do you do self breast exams?

Yes No ☐

Date of last mammogram:____

Patient Name: _____Date:_____