BODY THERAPEUTICS

Thank you for visiting Body Therapeutics. Please help us to provide you with a thorough evaluation and treatment by completing this questionnaire to the best of your ability. All information is kept confidential. Please ask your practitioner any questions you may have.

PERSONAL INFORMATION

Name: Date of Birth:

Address: City, State, Zip

Telephone Number: Alternative Number:

Email Address:

Who referred you to our center?

Emergency Contact: Telephone Number:

Occupation:

Hobbies/Activities:

PCP or Other Medical Practitioner Name:

PCP's Address:

PCP's Telephone Number:

☐ Please check and initial below if we may we share information with your PCP.

_____ Client initials indicate permission granted to contact above listed physicians and medical professionals to share health information and communicate treatment progress to coordinate care and obtain referrals.

MAIN COMPLAINT

Main problem you would like us to help with:

How long ago did this problem begin?

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

What kinds of treatment have you tried for this problem:

- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Massage
- ☐ Physical Therapy
- ☐ Reiki
- ☐ Western Medicine (please describe): _____
- ☐ Nutritional Counseling
- ☐ Other _____

SECONDARY COMPLAINTS

Are there any other problems that you would like us to address:

PERSONAL MEDICAL HISTORY

Height: Current weight: Weight history:

Please check any of the following that you have experienced:

- ☐ Asthma
- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Venereal disease
- ☐ Other _____

Please list all hospitalizations and surgeries with approximate dates:

Please list any significant trauma (accidents, falls, loss, etc.):

Please list all allergies (food, drugs, metals, etc.):

Please list all medicines, vitamins, herbal remedies, supplements, etc., taken within last 2 months:

Name	Dosage	Reason for taking

LIFESTYLE

Do you follow any type of special diet (i.e. vegetarian, gluten-free, etc)? YES NO
If so, what type of diet and for how long?

Please describe your average daily diet:

Morning:

Late morning:

Afternoon:

Late afternoon:

Evening:

Late night:

How many 8oz. glasses of water do you drink per day?

Do you smoke? YES NO If so, how many cigarettes per day for how long?

How many cups of caffeinated coffee, tea and soda do you drink per week?

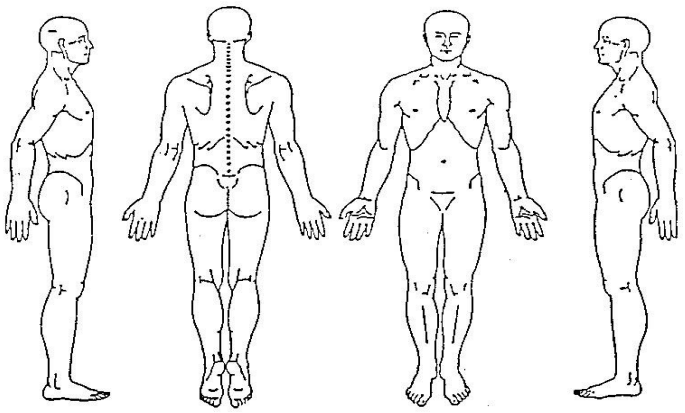
How many alcoholic beverages do you drink per week?

Please list any use of drugs for non-medicinal purposes:

Do you have a regular exercise regimen? YES NO If yes, please describe:

Are there areas of your life that you find stressful? YES NO If yes, please describe:

Please indicate any painful or distressed areas of your body by circling or marking the particular area.



GENERAL

Please check any and all that apply.

Body Temperature:

- ☐ Feel warm all the time
- ☐ Feel cold all the time
- ☐ Fevers
- ☐ Chills
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Spontaneous sweats
- ☐ Cold hands
- ☐ Cold feet
- ☐ Crave cold drinks
- ☐ Crave warm drinks
- ☐ Neutral drinks

Sleep:

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Waking unrested
- ☐ Vivid dreams
- ☐ Troublesome dreams
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Crave naps
- ☐ Take naps
- ☐ Grinding teeth
- ☐ Hours per night: _____

Energy Level:

- ☐ Always feel tired
- ☐ Tired but I keep going
- ☐ Energy is consistently good
- ☐ Can't sit still
- ☐ Sudden drops in energy, if so when: _____

Skin & Hair:

- ☐ Rashes
- ☐ Eczema
- ☐ Pimples
- ☐ Psoriasis
- ☐ Hives
- ☐ Dermatitis
- ☐ Itching
- ☐ Dry skin
- ☐ Dandruff
- ☐ Premature graying
- ☐ Hair loss
- ☐ Change in texture

Head, Eyes, Ears, Nose & Throat:

- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Trouble concentrating
- ☐ Memory loss
- ☐ Eye pain/strain
- ☐ Cataracts
- ☐ Poor/blurry vision
- ☐ Spots/floaters
- ☐ Night blindness
- ☐ Ringing in ears
- ☐ Difficulty hearing
- ☐ Earaches
- ☐ Sinus pain
- ☐ Nosebleeds
- ☐ Frequent sore throat
- ☐ Pit in throat feeling
- ☐ Canker sores
- ☐ Clenching jaw
- ☐ Dental pain

Cardiovascular:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Palpitations
- ☐ Spider veins
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Swelling of feet
- ☐ Swelling of hands
- ☐ Fainting
- ☐ Blue lips
- ☐ Blue fingernails
- ☐ Raynauds

Respiratory:

- ☐ Asthma
- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Recurrent bronchitis
- ☐ Pneumonia
- ☐ Chest tightness
- ☐ Shortness of breath
- ☐ Pain with deep breath
- ☐ Phlegm stuck in chest
- ☐ Phlegm produced:

Color _____

Gastro-Intestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Acid reflux
- ☐ Belching
- ☐ Bad breath
- ☐ Bleeding Gums
- ☐ Bloating
- ☐ Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ IBS/Crohn's
- ☐ Abdominal pain
- ☐ Laxative use
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Hernia
- ☐ Colitis

Genito-Urinary:

- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Pain upon urination
- ☐ Blood in urine
- ☐ Recurrent UTI
- ☐ Kidney stones
- ☐ Color
- ☐ Kidney infections
- ☐ Impotence
- ☐ Waking to urinate

Times/nt: _____

Reproductive & Gynecological:

Are you pregnant? YES NO Is it possible you *could* be pregnant? YES NO

Date of last period: Age at first period: No. days in cycle:

Number of Days of bleeding: Volume: LIGHT NORMAL HEAVY

Color of your menstrual blood (please circle): PALE RED BRIGHT RED DARK RED DARKER

Please check all that apply:

- ☐ Menstrual clots
- ☐ Premenstrual cramps
- ☐ Ovulation pain
- ☐ Irregular periods
- ☐ PCOS
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Vaginal dryness
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Breast soreness
- ☐ Breast cysts

Please describe any current or past birth control pill use (type, duration):

Have you ever been pregnant before? YES NO

Number of pregnancies:_____ Live births: _____ Premature births: _____

Miscarriages:_____ Abortions:_____

Neuro-Musculoskeletal: Please refer to page 3 to mark the area of pain on the diagram.

- ☐ Muscle tightness
- ☐ Muscle weakness
- ☐ Sprain/strain
- ☐ Carpal tunnel
- ☐ Muscle soreness
- ☐ Tendonitis
- ☐ Restricted mobility
- ☐ Numbness
- ☐ Muscle spasm
- ☐ Bursitis
- ☐ Sciatica
- ☐ Loss of balance
- ☐ Please describe the nature, location and diagnosis for any musculoskeletal pain

Psychological & Emotional:

- ☐ Anxiety
- ☐ Sadness
- ☐ Manic depression
- ☐ Fearful
- ☐ Excessive worry
- ☐ Depression
- ☐ Bad temper
- ☐ Grief
- ☐ Panic attacks
- ☐ Bi-polar
- ☐ Easily stressed
- ☐ Excessive laughter

Comments: Please use this section to describe anything else that hasn't already been addressed on this form.

I have read this entire document and have answered all of the questions to the best of my knowledge.

_____ _____

Last Name, First Name (please print) Signature

_____

Date