Les Moore ND, DHANP, CCH, LAc.
55 Sully's Trail, Ste. E
Pittsford, NY 14534
(585) 267-7339

Patient Name: _____

Date of Birth: _____

Your appointment with Les Moore ND, DHANP, CCH, L.Ac. is scheduled on

_____, ___/___/___ at ___:___ am/pm.

Please print and complete ALL the attached forms in their entirety and bring the packet to the office on the day of your appointment. Some questions may not apply for children and may be left blank.

Please be aware that payment for services is expected at the time of your appointment. The fee* for your initial appointment with Dr. Moore is $300. Follow up appointments are $90. *Pediatric appointments (ages 17 and under) are $200 for the initial appointment and $90 for follow-up appointments.* **Health insurance does NOT cover Naturopathic Medicine**. If you would like receipts to submit for Flexible Spending Account reimbursement, or for out-of-network acupuncture reimbursement, let the receptionist know and we will process the information and mail it to you.

If you have additional questions, please contact our office at 585-267-7339.

If you need to reschedule your appointment, please be advised that we require 24 hour notice to cancel or reschedule without a cancellation fee.

"No Show, No Call" appointments will be billed to you at the regular service rate.

Thank you for contacting our office for your health care needs.

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Acknowledgement of Financial Policies

If you need to cancel or reschedule, your consideration of others seeking treatment in your place is greatly appreciated. **We will bill you for no show appointments or canceling with less than 24 hours notice.**

By signing below, I acknowledge that I understand the following policies:

- I will be charged the normal fee for treatment if I miss an appointment without canceling or if I cancel with less than 24 hours notice.
- I will be charged $25 for returned checks.
- Payment is due at the time of treatment.
- I will be responsible for full payment for my service, even if I am late for my appointment. It is my responsibility to arrive on time.
- I agree to keep my account balance current by paying at each visit. I understand that I may pay by cash, check or any major credit card, or by gift card for approved services.
- Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current.

_____
Printed name of patient

_____ _____ _____
Signature of Patient or Legal Guardian Date Time

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Patient Name: _____

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Patient Financial Responsibility Agreement
Non-Covered Services

The provider who signed this form below has explained to me, the patient that my health Plan has determined that the health services described below are **not covered** under my health benefit plan for **the following reason** (note checked box):

X The health service is not a covered benefit under my health benefit plan.

□ I did not contact my health care professional to obtain the required referral for my visit to this provider. The provider informed me that failure to do so would mean that the care and services I receive will not be covered.

□ I am subject to a waiting period for a pre-existing condition, and I have not completed the required waiting period for the treatment of this pre-existing condition.

□ I have exhausted my allotment of this benefit.

□ Although this provider participates with my Health Plan, the services I have requested are not within the scope of this provider's participation agreement with the Health Plan.

I have directed the provider whose signature appears below to render the health services requested. I understand that:

- **The Health Plan will not pay the charges for these services, in whole or in part.**
- **The provider will not submit a claim to the Health Plan.***

I hereby agree to pay this provider in full for the cost of the health services described below. The provider disclosed this information to me and I signed this agreement **before** the provider supplied the specified health services to me.

If I am an HMO member, my signature does not imply, nor shall it be interpreted as being, a waiver by me of my rights to grieve and appeal under Public Health Law (PHL) Article 44, or to appeal an initial or final adverse determination under PHL Article 49 or Insurance Law Article 49. If I am an enrollee under an employer-sponsored self-insured plan, I do not waive my grievance and appeal rights under that health plan.

Description of Service:
Naturopathic Medicine w/ Acupuncture Initial Consultation ……**Cost for Service** $ 300.00 adult
…….. $200.00 child

Naturopathic Medicine w/ Acupuncture Follow Up……..**Cost for Service** $ 90.00 adult
…… $ 90.00 child

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Patient Signature Today's Date

Dr. Les Moore, ND, DHANP, CCH, LAc
Provider Name

_____
Provider Signature

Les Moore ND, DHANP, CCH, LAc.
55 Sully's Trail, Ste. E
Pittsford, NY 14534
(585) 267-7339

Patient Name: _____

Date of Birth: _____

Consent for Acupuncture

1. I hereby authorize Les Moore, Licensed Acupuncturist, to perform acupuncture and/or other procedures associated with oriental medicine upon me or the named patient. I understand that acupuncture is a technique used to relieve pain in a specific area of the body.
2. I am aware that methods of treatment may include, but not be limited to acupuncture, moxibustion (use of heated mugwort near certain acupuncture points), cupping (use of warm air in glass jars on areas of the body), massage, electrical stimulation, nutritional counseling and herbal medicine.
3. Some acupuncture points and herbal medications should not be used during pregnancy. Therefore, I agree to notify Les Moore if I believe I may be pregnant.
4. I further agree to notify Les Moore if I am diabetic, since the decreased sensation that is frequently associated with diabetes may increase the likelihood of burns, blisters or other injury from moxibustion, cupping or insertion of acupuncture needles.
5. Les Moore has fully explained to me the purpose of acupuncture and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. The risks discussed include, but are not limited to: allergic reaction to herbal medications and/or mugwort; bruising, numbness and tingling at the sites where acupuncture needles are inserted; burns and blisters from moxibustion, and bruises or non-permanent skin marks from cupping. I agree to notify Les Moore if I experience any unpleasant or unanticipated side effects from my acupuncture treatment.
6. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
7. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from acupuncture. In addition, potential problems that might occur during recuperation have been explained to me.
8. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above that do not pertain to me.

_____ _____ _____

Signature Patient/Relative/Guardian* Print Name Today's Date

_____

Relationship to Patient

**The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.*

Patient Advisory to Consult Physician

As an acupuncturist, I believe strongly in and am committed to oriental medicine. However, I recommend that you consult with your physician regarding any condition or conditions you have prior to seeking acupuncture treatment. **State law requires that you read and sign the following statement:**

We, the undersigned, do affirm that (Print Patient Name) _____ has been advised by Les Moore, LAc., to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____ _____ _____

Patient's Signature Acupuncturist's Signature Date

Les Moore ND, DHANP, CCH, LAc.
55 Sully's Trail, Ste. E
Pittsford, NY 14534
(585) 267-7339

Patient Name: _____

Date of Birth: _____

Health History Intake Form

Today's date: _____

Name (Last): _____ (MI): _____ (First): _____

Date of Birth: _____ Age: _____Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: HOME ( )_____ WORK ( )_____ CELL ( ) _____
Do we have permission to leave a message on answering machine or voicemail?
Please mark any that you give permission for: HOME _____ WORK _____ CELL _____

Parent Or Guardian (For Minor Patient): _____

Name Of Emergency Contact: _____ Phone: ( )_____

How Did You Hear About Us? _____

If you would like to receive emails from The Springs to receive information about educational programs, news, articles, or special promotions, please provide your email address. You may choose to unsubscribe at any time and your email will never be sold or shared with any other list.
EMAIL:

Please complete this 2-sided questionnaire as thoroughly as possible. This is a confidential record of your medical history and will not be released except when you authorize us to do so or if required by law.

Please List Medications That You Are Currently Taking, With Dosages: (Please include prescription and non-prescription drugs. Ex: allergy medications, aspirin, Tylenol, Advil, laxatives, oral contraceptives, hormones etc.)

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____
7) _____ 8) _____

Do you use Retin-A for skin conditions? ☐YES ☐NO

List vitamins, minerals, herbs, and/or homeopathic remedies presently taking, with dosages:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____
7) _____ 8) _____

Please list any known allergies to the following: (Explain the reactions)

Drugs: _____

Foods (include gluten, nuts, seafood, iodine, etc.): _____

Environmental (grasses, pollens, animal dander, etc.): _____

_____

What goals do you have for your visit today?

Primary goal: _____

Other goals: _____

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Patient Name: _____

Date of Birth: _____

For WOMEN, are you pregnant or trying to become pregnant? ☐YES ☐NO If Yes, #_____ weeks gestation.

Please mark any conditions that you have now or have had in the last year:

HEAD SYMPTOMS
- □ Headache
  - TYPE: □ Migraine
  - □ Sinus
  - □ Tension
- □ Loss of memory
- □ Light- headedness
- □ Dizziness / vertigo
- □ Fainting
- □ Loss of balance

NECK
- □ Pain in neck
- □ Stiff neck
- □ Pinched nerve in neck
- □ Neck feels out of place
- □ Muscle spasm in neck
- □ Loss of Range of Motion
- □ Bone spurs in neck
- □ Arthritis in neck
- □ Whiplash (date)___/___/____
- □ Any neck SURGERY:

Explain:_____

_____

_____

EARS

- □ Loss of hearing

Do you wear hearing aids? ___

- □ Pain in ears
- □ Ringing in ears

MID-BACK
- □ Mid- Back pain
- □ Pain btw. shoulder blades
- □ Sharp stabbing pain
- □ Muscle Spasm
- □ Arthritis in back
- □ Scoliosis

LOW BACK
- □ Low back pain
- □ Pinched nerve in low back
- □ Low back feels out of place
- □ Muscle spasm
- □ Arthritis
- □ Sciatica

Describe your low back pain:
- □ Throbbing □ Stabbing
- □ Sharp □ Aching
- □ Burning □ Electrical

Does your pain radiate? _____

Explain: _____

_____

_____

□ Have you had back SURGERY:

Explain: _____

_____

_____

□ Herniated Discs? _____

_____

SHOULDERS
- □ Pain in shoulder joint
- □ Pain in shoulder muscle
- □ Bursitis: Right / Left
- □ Arthritis: Right / Left
- □ Can't raise arm
  - □ above shoulder level
  - □ over head
- □ Tension in shoulders
- □ Pinched nerve - shoulder
- □ Muscle spasms - shoulder
- □ Radiating pain down arm
- □ Throbbing pain in elbow or back of arm

ARMS & HANDS
- □ Pain-upper arm: Right / L
- □ Pain-forearm: Right / Left
- □ Pain-hands: Right / Left
- □ Pain-fingers: Right / Left
- □ Numbness/Tingling
  - □ WRIST: Right / Left
  - □ FINGERS: Right / Left
- □ Hands cold: Right / Left
- □ Swollen joints in fingers
- □ Sore joints in fingers
- □ Arthritis in fingers
- □ Carpal Tunnel

HIPS, LEGS, & FEET
- □ Pain in buttock
- □ Pain in hip joint
- □ Pain down leg
- □ Pain down both legs
- □ Leg cramps
- □ Pins/ needles in legs
- □ Numbness of feet
- □ Cramps in feet
- □ Swollen ankles
- □ Swollen feet R-L
- □ Painful joints in toes
- □ Varicose veins
- □ Recent blood clots
- □ Arthritis hip, knees, feet
- □ Phlebitis

MENTAL/EMOTIONAL
- □ Nervousness
- □ Irritable
- □ Fatigue
- □ Twitching
- □ Numbness
- □ Grief
- □ Tension / Stress
- □ Depression
- □ Anxiety
- □ Insomnia
- □ Claustrophobia
- □ Other: _____

_____

CARDIO/RESPIRATORY
- □ Chest pain
- □ High blood pressure
- □ Low blood pressure
- □ Swelling in ankles
- □ Chronic cough
- □ Pacemaker
- □ Congestive Heart Failure
- □ Coumadin, Warfarin, etc.
- □ Stroke
- □ Blood clots / embolism

OTHER ORGAN SYSTEMS
- □ Nervous stomach
- □ Nausea
- □ Gas
- □ Constipation
- □ Diarrhea
- □ Vomiting
- □ Frequent urination
- □ Dermatitis/Excema
- □ Psoriasis
- □ Other Skin Condition:

_____

HAVE YOU BEEN DIAGNOSED W/ THE FOLLOWING?
- □ Diabetes
- □ Fibromyalgia
- □ Multiple Sclerosis
- □ Rheumatoid Arthritis

Areas affected:

_____

_____

- □ Crohn's Disease
- □ Ulcerative Colitis
- □ Lupus
- □ ALS
- □ Muscular Dystrophy
- □ Scleroderma
- □ Cancer

Type: _____

When: _____

Treatment: _____

- □ Lymph Nodes Removed?

How many? _____

Where? _____

- □ Communicable Disease
- □ Other: _____

_____

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Patient Name: _____

Date of Birth: _____

History of Surgeries: _____

Recent Injuries? Please describe: _____

Please list any other medical conditions, symptoms, or situations that practitioner should be aware of prior to your treatment:

_____

Are you currently receiving medical care? ☐YES ☐NO May we contact your care provider?: ☐YES ☐NO

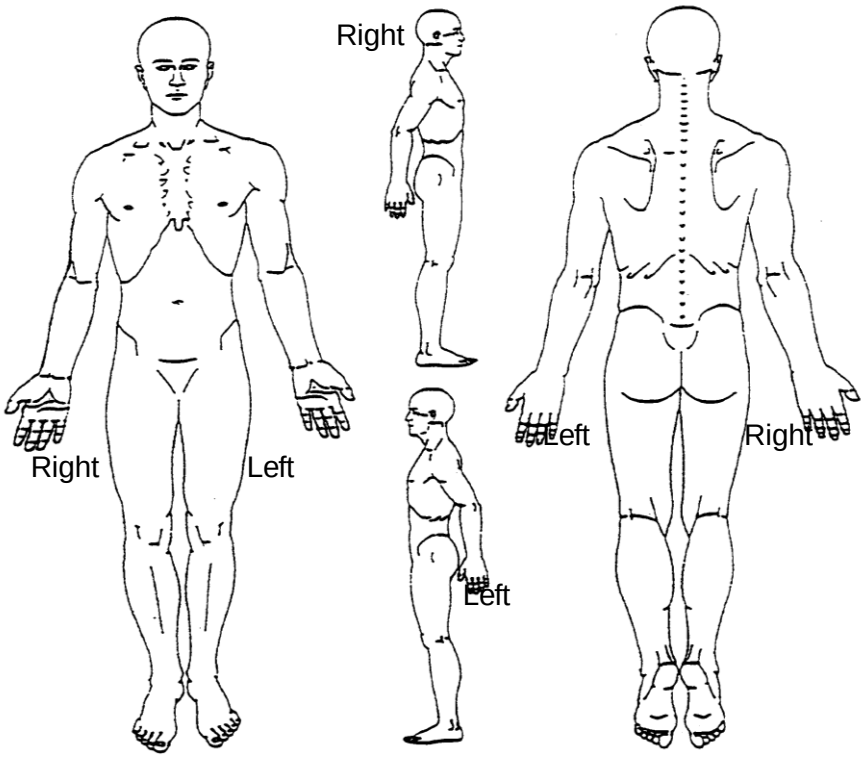
If YES, for what condition(s)? _____

Name & Contact information of physician: _____

If NO, when and where did you last receive medical health care? _____

What was the reason? _____

Please mark the areas you have pain, tension, or concerns:



Please circle the number below that represents your level of pain today.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

Have you received a professional massage before? ☐YES ☐NO

Have you received any esthetic/skincare/nail service before? ☐YES ☐NO

Have you had any problems or reactions to products before? ☐YES ☐NO

If yes, please explain: _____

The information I have provided is true and complete to the best of my knowledge. I agree to inform my practitioner of any changes in my health prior to treatment.

_____ _____

Patient Signature Date

Naturopathic Patient Profile

Les Moore ND, DHANP, CCH, LAc.
55 Sully's Trail, Ste. E
Pittsford, NY 14534
(585) 267-7339

Patient Name: _____

Date of Birth: _____

Present Health Concerns: (Please list most important ones first and indicate when you first noticed the problem)

1) _____

2) _____

3) _____

4) _____

5) _____

Please provide the names of other health care professionals you are seeing and their specialty: _____

_____

What diagnosis were you given? _____

_____

Have you ever consulted a naturopath before? ☐Yes ☐No

Have you ever consulted an acupuncturist before? ☐Yes ☐No

Do you have any questions about naturopathic medicine or acupuncture before we get started? ☐Yes ☐No

_____

PAST HISTORY:

Hospitalizations: (Please indicate reasons/dates): _____

Serious illnesses and injuries: _____

SOCIAL HISTORY:

Please check those that apply: ☐Single ☐Married ☐Significant Other ☐Separated ☐Divorced ☐Widowed

Do you have children? _____ If so, how many? _____ Please list their ages: _____

_____

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Patient Name: _____

Date of Birth: _____

CHILDHOOD:

How was your health as a child? (Check one) ☐excellent ☐good ☐fair ☐poor

Were there any complications with your delivery? Explain._____

_____

Were you breast fed? _____ How long? _____

Did you have any serious emotional, mental or physical traumas as a child? Please explain. _____

_____

_____

_____

Do you have siblings? (indicate age and sex) _____

IMMUNIZATIONS: (Check those that apply)

- ❑ Measles
- ❑ Mumps
- ❑ Rubella
- ❑ Small pox
- ❑ Influenza
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Hepatitis B
- ❑ Varicella-Chicken Pox
- ❑ HPV-Human Papilloma Virus
- ❑ Other _____

BLOOD TYPE:

What is your blood type? (Check one) ☐A ☐B ☐AB ☐O ☐don't know

TEST HISTORY:

Please check box and indicate date of last procedure. Circle any tests that were abnormal and explain in space provided below.

Test	Date	Test	Date	Test	Date
❑ Chest X-ray		❑ Cholesterol		❑ PSA	
❑ Spine X-ray		❑ Chemistry Panel		❑ Complete Physical Exam	
❑ Blood Tests		❑ Pap Smear		❑ DEXA	
❑ EKG		❑ Mammogram		❑ Others (Please list)	
❑ MRI		❑ Sigmoidoscopy			
❑ CAT Scan		❑ Colonoscopy			
❑ Cardiac Stress Test		❑ Rectal exam			

_____

_____

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Date of Birth: _____

FAMILY HISTORY:
Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "RELATION" column when appropriate.

	YES	RELATION	COMMENTS		YES	RELATION	COMMENTS
Alcoholism				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other			

FOR WOMEN:
Age at onset of menstruation?_____ Any period of time without a menstrual cycle, if so how long? _____

Any use of oral contraceptives? If so, how long? _____

History of miscarriages, C-sections and/or abortions?: _____

_____

Age at onset of menopause? _____ Any hormone replacement therapy, if so how long? _____

Date of last Pap Smear: _____ Results Were: (circle one) Normal Abnormal Don't know

Date of last mammogram:_____ Results: (explain) _____

PERSONAL HABITS:
Do you:

- ❑ Use tobacco _____ packs per day How many years? _____ Date Quit: _____
- ❑ Drink coffee _____ cups per day
- ❑ Drink black tea _____ cups per day
- ❑ Drink alcohol _____ glasses per day
- ❑ Drink sodas _____ glasses per day
- ❑ Use artificial sweeteners _____ packets per day
- ❑ Use margarine _____ pats per day
- ❑ Use recreational drugs

How many times a week do you eat in a restaurant? Breakfast_____ Lunch_____ Dinner_____

What types of restaurants? _____

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

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Date of Birth: _____

OTHER QUESTIONS

What are your favorite foods? _____

Do you crave sweets?_____ Any particular time of the day? _____

Do you salt your food at the table? _____

What foods do you really dislike? _____

Do you drink purified or bottle water? _____ If so, what brand do you use? _____

Do you make an effort to eat organic foods? _____ If so, what percentage of your diet?_____

Are you on a restricted diet due to religious or other beliefs? Please explain. _____

_____

Would you like to increase or decrease your weight? If so, by how much? _____

When did you last have a significant weight change (more than 10 pounds)? _____

What exercise do you do and how often? _____

How many hours of sleep do you get each night? _____ Do you wake rested? _____

Are you presently sexually active? _____ Any difficulties? _____

Method of birth control? _____

Rate your current stress level from 1-10 (10= most stress)_____ How much does this affect you? ____

What are the major stress factors in your life now? _____

Please rate your current emotional health? (please circle) Excellent Good Fair Poor Unstable Crisis

Are you currently in psychotherapy?_____ Do you have a good support network? _____

Does your home environment have a supportive effect on your health? _____

How many hours of relaxation (not including sleep) do you give yourself during the work week? _____

During the weekends? _____

How many vacations do you take per year? _____

What are your favorite recreational activities? _____

_____

When was your last eye exam? _____ Do you wear contacts? _____ Hard or Soft? _____

Do you have any visual impairments, if so, what are they? _____

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

Are you considering any elective surgery or medical procedure in the near future? _____

Are you or have you ever been exposed to any toxic chemicals? _____

If yes, which ones? _____

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HEALTH AND LIFESTYLE OVERVIEW

Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factor that you think may have played a role in its onset and progression. Please attach a sheet if more space is required.)

Is your health currently getting better, worse, or staying the same. How do you know?

What have you tried to do to improve your state of health (ex. other doctors, treatments, etc.)?

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)

Please list any other health concerns/conditions, even if you think they may not be important.

Why did you choose this clinic?

For our time together to be a true win for you, what do you want to take place over the course of your care here?

How long do you feel this will take?

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, "I need some help…let's change some things here!" Please share your thoughts.

Do you feel your pain and/or illness is a reflection of a short-term superficial circumstance or longer-term potentially deeper-seated challenges? Please share your thoughts.

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Patient Name: _____

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What areas of your lifestyle are likely involved with your condition and you would like to improve (prioritize: 1, 2, 3 etc):

___My level of anxiety
___My pace of living
___Not enough quiet time and rest
___My diet and nutrition program
___My exercise program
___Other Explain:_____

___Not enough time spent in nature
___My creative expression
___My feelings around career
___My social and family life
___My communication skills

What behaviors or lifestyles habits do you currently engage in regularly that you believe support your health (please list)

What behaviors or lifestyles habits do you currently engage in regularly that you believe are destructive lifestyle habits (example: smoking, lack of exercise, addictions, etc.)? (please list)

What might it cost you if you don't significantly improve your lifestyle and underlying contributing factors to compromised health? (For example, vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to change any underlying causes of your signs and symptoms which relate to your lifestyle? (rate from 0 to 10 with a 10 = 100% committed)

0% 1 2 3 4 5 6 7 8 9 10 100%

List your 3 highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?

1)

2)

3)

What obstacles could prevent you from changing those lifestyle factors undermining your health?

What might stop you from following the therapeutic protocols that I may prescribe for you?

Who would be willing to support you in your health goals?

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Please list your special interests and passions:

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DIET SURVEY Please list everything you eat and drink for 2-3 days.

Day	Breakfast	Snack	Lunch	Snack	Dinner	Snack
1						
2						
3						

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Patient Name: _____

Date of Birth: _____

CHECK ALL THAT APPLY:

LIFESTYLE ❑ Alcohol ❑ Tobacco	❑ Marijuana ❑ Drugs	❑ Stress ❑ Occupational hazards	❑ Regular exercise ❑ Type:_____ ❑ Type:_____	❑ Frequency:_____ ❑ Frequency:_____
GENERAL SYMPTOMS ❑ Poor appetite ❑ Big appetite ❑ Strongly likes cold drinks ❑ Strongly likes hot drinks ❑ Recent weight loss/gain	❑ Poor sleep ❑ Heavy sleep ❑ Dream-disturbed sleep ❑ Fatigue ❑ Lack of strength	❑ Heavy sensation in body ❑ Cold hands or feet ❑ Poor circulation ❑ Shortness of breath ❑ Fever	❑ Chills ❑ Night sweats ❑ Sweats easily ❑ Muscle cramps ❑ Vertigo or dizziness	❑ Bleeds easily ❑ Bruises easily ❑ Peculiar taste in mouth (explain)_____
HEAD, EYES, EARS, NOSE & THROAT ❑ Glasses ❑ Eye strain ❑ Eye pain ❑ Itchy eyes or burning eyes ❑ Sees spots in visual field ❑ Poor vision ❑ Blurred vision ❑ Night blindness	❑ Glaucoma ❑ Cataracts ❑ Teeth problems ❑ Grinds teeth ❑ TMJ ❑ Facial pain ❑ Gum problems ❑ Hoarseness	❑ Sores on lips, tongue or in mouth ❑ Dry mouth ❑ Excessive saliva ❑ Sinus problems ❑ Excessive phlegm ❑ Color of phlegm_____ ❑ Recurrent sore throat	❑ Swollen glands ❑ Lump in throat ❑ Enlarged thyroid ❑ Nosebleeds ❑ Ringing in ears ❑ Poor hearing ❑ Earaches ❑ Ringing in ears	❑ Headaches ❑ Migraines ❑ Concussions ❑ Other head and neck problems (explain)
RESPIRATORY ❑ Shortness of breath on exertion ❑ Shortness of breath without exertion	❑ Difficulty breathing when laying down ❑ Asthma ❑ Wheezing	❑ Cough ❑ Coughing blood ❑ Pneumonia ❑ Chronic Bronchitis	❑ Color of phlegm_____ ❑ History of Tuberculosis	
CARDIOVASCULAR ❑ High blood pressure ❑ Low blood pressure	❑ Fainting ❑ Chest pain	❑ Difficulty breathing ❑ Cyanosis ❑ Heart palpitations	❑ Irregular heartbeat ❑ Murmurs ❑ Arrhythmias	❑ Swelling ❑ Intermittent severe pain in calf when walking
GASTROINTESTINAL ❑ Nausea ❑ Vomiting ❑ Acid regurgitation ❑ Gas ❑ Bloating	❑ Hiccups ❑ Bad breath ❑ Diarrhea ❑ Constipation ❑ Laxative use	❑ Black stools ❑ Bloody stools ❑ Mucus in stools ❑ Abdominal pain ❑ Rectal pain	❑ Hemorrhoids ❑ Anal fissures ❑ Intestinal pain/cramping ❑ Itchy anus ❑ Burning anus	Bowel movements ❑ Frequency:_____ ❑ Color:_____ ❑ Texture:_____ ❑ Odor:_____ ❑ Undigested food (Y / N)
MUSCULOSKELETAL ❑ Neck pain/tightness ❑ Shoulder pain/tightness ❑ Upper back pain/tightness	❑ Low back pain/tightness ❑ Joint pain ❑ Rib pain	❑ Swelling ❑ Arthritis	❑ Limited range of motion ❑ Limited use	❑ Other (describe)_____
SKIN, HAIR & NAILS ❑ Rashes ❑ Hives ❑ Ulcerations	❑ Eczema ❑ Psoriasis ❑ Acne	❑ Dry skin ❑ Itching ❑ Dandruff	❑ Hair loss ❑ Change in hair /skin/nail texture	❑ Fungal infections
NEUROPSYCHOLOGICAL ❑ Seizures ❑ Numbness or Tingling ❑ Speech problems ❑ Weakness/paralysis	❑ Tics or Tremors ❑ Loss of sensation ❑ Gait problems ❑ Coordination problems	❑ Memory loss ❑ Easily stressed ❑ Anxiety ❑ Irritability	❑ Phobias ❑ Depression ❑ Abuse survivor ❑ Considered suicide	❑ Attempted suicide ❑ Seeing therapist ❑ Other (explain)
GENITO-URINARY ❑ Pain on urination ❑ Frequent urination ❑ Urgent urination	❑ Blood in urine ❑ Unable to hold urine ❑ Incomplete urination	❑ Venereal disease ❑ Bedwetting ❑ Wake to urinate	❑ Increased libido ❑ Decreased libido ❑ Kidney stones	❑ Impotence ❑ Premature ejaculation ❑ Nocturnal emissions
GYNECOLOGY ❑ Length of cycle (from day 1 to day 1)_____ ❑ Duration of flow_____	❑ Any clots ❑ Date of last period ❑ Spotting ❑ Irregular periods	❑ Painful periods ❑ PMS explain:_____	❑ Vaginal discharge. What color?_____ ❑ Vaginal sores ❑ Vaginal odor	❑ Age at menopause_____ ❑ Menopausal symptoms (explain)_____

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Patient Name: _____

Date of Birth: _____

OTHER				
❑ History of anemia ❑ History of blood transfusion	❑ Lymph node enlargement ❑ Lymph node pain	❑ Breast tenderness/pain ❑ Nipple discharge		