Active Lifestyle Clinic | KEEPING YOU ACTIVE FOR LIFE

Medical Case History

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail Address:_____Fax # _____ Cell Phone:_____

How do you prefer to be contacted by us? Text Email If Text: Which carrier do you use? _____

Birth Date:_____ Marital Status: □ Married □ Partner □ Single □ Widowed □ Divorced

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse Name:_____ # children?_____ Names and Ages children:_____

_____

Emergency Contact:_____ Phone:_____

How were you referred to our office?_____

Preferred Pharmacy:_____

HISTORY OF PRESENT AND PAST ILLNESS:

Reason for office visit:

1. _____ Date condition began: _____
2. _____ Date condition began: _____
3. _____ Date condition began: _____

Are you recovering from a cold or flu? _____ Are you pregnant? Y N

List any health problems you are currently being treated for:

_____

_____

_____

What types of therapies have you tried for these problems or to improve your overall health?

□ diet □ fasting □ vitamins/minerals □ herbs □ naturopathy □ chiropractic □ acupuncture

□ conventional drugs □ other _____

Do you experience any of these general symptoms EVERY DAY?

□ Panic attacks □ Shortness of breath □ Insomnia □ Constipation □Itching/rash

□ Chronic pain/Inflammation □ Bleeding □ Depression □ Debilitating fatigue

□ Fecal Incontinence □ Poor wound healing □ Discharge □ Dizziness

□ Disinterest in sex □ Nausea/Vomiting □ Urinary Incontinence □ Low grade fever

Laboratory procedures performed in last 6mo (blood, imaging, etc.)_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle your level of stress on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (eg, work, finances, relationship(s), etc)_____

_____

What is your overall energy level on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Do you fall asleep easily? Y N **Do you sleep through the night?** Y N **Do you wake rested?** Y N

Do you consider yourself: □ underweight □ overweight □ just right

Your weight today_____lbs Your weight at age 20_____lbs Your ideal weight_____lbs

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? Y N

How committed are you to making a change in your health (1 = least, 10 = most committed):

1 2 3 4 5 6 7 8 9 10

Do you tend to be sensitive to medications? Y N

Current medications (prescriptions and over-the-counter):_____

_____

Current supplements:_____

_____

List any known allergies: _____

List any known drug allergies: _____

Check all that Apply
□ Arthritis
□ Allergies/hay fever
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Anxiety
□ Autoimmune disease
□ Blood pressure problems
□ Bronchitis
□ Cancer
□ Chronic fatigue syndrome
□ Carpal tunnel syndrome
□ Chest pain
□ Cholesterol, elevated
□ Circulatory problems
□ Dental problems
□ Depression
□ Diabetes
□ Diverticular disease
□ Drug addiction
□ Eating disorder
□ Epilepsy/seizures
□ Emphysema
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Gastroesophageal reflux disease
□ Genetic disorder
□ Glaucoma
□ Gout
□ Heart disease
□ Infection, chronic
□ IBD/colitis
□ Irritable bowel syndrome
□ Kidney or bladder disease
□ Liver or gallbladder disease (stones)
□ Mental illness
□ Migraine headaches
□ Neurological problems (Parkinson's, paralysis, etc)
□ Stroke
□ Thyroid problems
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually transmitted disease
□ Skin problems
□ Tuberculosis
□ Ulcer
□ Urinary tract infection
□ Varicose veins
Other _____

Medical (Women)
□ Menstrual irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic breasts
□ Fibroid/ovarian cysts
□ PMS (premenstrual syndrome)
□ Breast cancer
□ Pelvic inflammatory disease
□ Vaginal infections
□ Decreased sex drive
□ Menopause
□ Surgical Menopause
□ C-section. How many_
PAP □ + □ –
Mammogram □ + □ –
Number of pregnancies_____
Number of children_____
Age of first period_____
Date of last period_____
Length of cycle__ days
Any recent changes in menstrual flow(eg. Heavier, more clots, etc)
_____

Medical (Men)
□ Benign prostatic hyperplasia
□ Prostate cancer
□ Decreased sex drive
□ Infertility

Family Health History (Parents and Siblings)
□ Arthritis
□ Asthma/lung disease
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune disease
□ Cancer
□ Depression
□ Diabetes
□ Drug addiction
□ Eating disorder
□ Genetic disorder
□ Glaucoma
□ Heart disease
□ Hypertension
□ Infertility
□ Mental illness
□ Migraine Headaches
□ Obesity
□ Osteoporosis
□ Stroke
Other_____

Health Habits
□ Smoke
□ Use alcohol
□ Caffeine (coffee, pop, etc)
Glasses of water/day_____
Hours of sleep/night_____
Number of stools/day_____
Consistency of stools:
□ Hard □ Soft □ Marbles
□ Normal □ Other

Exercise
□ none
□ 1 to 2 days per week
□ 3 to 4 days per week
□ 5 to 7 days per week
□ Less than 45 minutes/day
□ More than 45 minutes/day

Nutrition & Diet
□ Mixed food diet (animal and vegetable sources)
□ Vegetarian
□ Vegan

Eating Habits
□ One meal per day
□ Two meals per day
□ Three meals per day
□ Graze (small frequent meals)
□ Eat constantly whether hungry or not

I Would Like To:
□ Feel more vital
□ Feel less pain
□ Lose weight
□ Improve memory
□ Be less indecisive
□ Increase sex drive
□ Use less medications
□ Have more endurance
□ Sleep better
□ Be stronger
□ Be less moody
□ Feel more motivated
□ Increase muscle tone
□ Slow down aging

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Allergies						
Anxiety or Depression						
Arthritis						
Asthma						
Autoimmune Disease						
Back Pain						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Headaches						
Heart Disease						
High Blood Pressure						
Insomnia						
Kidney Disease						
Liver Disease						
Migraine						
Neck Pain						
Obesity						
Osteoporosis						
Scoliosis						
Intestine Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____