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Re-Exam Patient Health Form

Name:

DOB: Date:

What has improved?

Has anything gotten worse?

Any new complaints?

Any change in medications?

Current weight? Changes?

Consistency in taking supplements %

LIST YOUR PRIMARY CONCERNS / GOALS IN ORDER OF IMPORTANCE:

1.
2.
3.
4.
5.

Please describe progress or concern in the following areas:

Digestion/Elimination:

Diet:

Immune/Allergy:

Sleep:

Pain or Headache:

Exercise:

CRAMPS/ACHES/RESTLESS

Leg	☐ Cramps	☐ Aches	☐ Restless
Feet	☐ Cramps	☐ Aches	☐ Restless
Arms	☐ Cramps	☐ Aches	☐ Restless
Hands	☐ Cramps	☐ Aches	☐ Restless

Other:

PAIN/STIFFNESS/SWELLING/NUMBNESS/TINGLING

TMJ	☐ Left	☐ Right
Upper Neck	☐ Left	☐ Right
Lower Neck	☐ Left	☐ Right
Upper Back	☐ Left	☐ Right
Shoulders	☐ Left	☐ Right
Elbows	☐ Left	☐ Right
Wrist	☐ Left	☐ Right
Hand	☐ Left	☐ Right
Mid Back	☐ Left	☐ Right
Low Back	☐ Left	☐ Right
SI Joint	☐ Left	☐ Right
Hips	☐ Left	☐ Right
Sciatica	☐ Left	☐ Right
Legs	☐ Left	☐ Right
Knees	☐ Left	☐ Right
Ankles	☐ Left	☐ Right
Feet	☐ Left	☐ Right

Other

Adult Case History

- [ ] Stress: scale 1-10
- [ ] Bowel Movement: x /wk
- [ ] Water: oz / day
- [ ] Juice: glasses / day
- [ ] Coffee: cups / day
- [ ] Soda: oz / day
- [ ] Alcohol: glasses / wk
- [ ] Tobacco: x / day
- [ ] Soy Use:
- [ ] Artificial Sweetener Use:
  - [ ] Equal (Aspartame)
  - [ ] Splenda (Sucralose)
- [ ] Cardio: x / wk
- [ ] Weight Train: x / wk
- [ ] Yoga/Pilates: x / wk
- [ ] Sports: hrs / wk

Rank any symptoms you are currently having 1 - 10 or check applicable boxes.

EARS
- [ ] Noise (Ring/Hiss/Pound)
- [ ] Plugged
- [ ] Popping
- [ ] Ache / Infection
- [ ] Draining
- [ ] Itchy
- [ ] Hearing Loss
- [ ] Dizziness/Vertigo
- [ ] Excessive Ear Wax
- [ ] Other:

EYES
- [ ] Burn / Tear / Itchy
- [ ] Ache / Dry / Red
- [ ] Crust in am / Film
- [ ] Bouts of Blurriness
- [ ] Floaters / Spots
- [ ] Tired / Puffy
- [ ] Stye
- [ ] Twitching around eye
- [ ] Dark circles
- [ ] Light sensitive
- [ ] Other:

SINUS
- [ ] Nosebleeds
- [ ] Dry
- [ ] Drain
- [ ] Stuffy/plugged
- [ ] Sneeze frequently
- [ ] Taste / Smell loss
- [ ] Post nasal drip

SKIN / HAIR / NAILS
- [ ] Skin Rash
- [ ] Acne
- [ ] Butt Acne
- [ ] Dry skin
- [ ] Eczema / Psoriasis
- [ ] Nails (white spots /ridges)
- [ ] Nails (weak / peeling)
- [ ] Hair loss
- [ ] Limp Hair
- [ ] Varicose / Spider veins
- [ ] Damp hands / feet
- [ ] Dandruff
- [ ] Red dots
- [ ] Bruise easily
- [ ] Bumps on Back of Arms
- [ ] Missing outer 1/3 of eyebrow
- [ ] Cold hands / feet
- [ ] Ingrown toenails
- [ ] Other:

- [ ] Heartburn
- [ ] Indigestion
- [ ] Stomach Ache / Cramps
- [ ] Nausea/Vomiting
- [ ] Bloat After Eat
- [ ] Gas / Flatulence
- [ ] Belching
- [ ] Ulcer
- [ ] Other:

BOWELS
- [ ] Diarrhea
- [ ] Constipation
- [ ] Incomplete
- [ ] Bulky
- [ ] Cramps in Abdomen
- [ ] Pain w/ Bowel Movement
- [ ] Laxative / Suppository Use
- [ ] Colonics / Enemas
- [ ] Anal Itching
- [ ] Hemorrhoids:
  - [ ] Swollen / Achy
  - [ ] Burning / Itchy
  - [ ] Blood
- [ ] Other:

STOOL CONSISTENCY
- [ ] Normal
- [ ] Light colored feces
- [ ] Soft
- [ ] Fluffy
- [ ] Hard
- [ ] Pebbles
- [ ] Ribbon-like
- [ ] Mucous
- [ ] Contain string-like
- [ ] Black / White specks
- [ ] Contain undigested food

APPETITE / DIET
- [ ] Low [ ] Normal [ ] High
- [ ] Crave Starch / Sweets
- [ ] Crave Salt
- [ ] Crave Chocolate / Ice Cream
- [ ] Eat lots of spicy foods
- [ ] Nighttime snack:
- [ ] If meals are missed:
- [ ] Nausea
- [ ] Extreme hunger
- [ ] Cold / Clammy
- [ ] Rapid heartbeat
- [ ] Irritability
- [ ] Light headed

LIBIDO / SEXUALITY
- [ ] Low [ ] Normal [ ] High

Orgasms:
- [ ] None [ ] Poor [ ] Good [ ] Great

CHEST
- [ ] Tension / Tight
- [ ] Pressure / Heaviness
- [ ] Congestion
- [ ] Chest / Sternal Pain
- [ ] Palpitations-Heart Skip
- [ ] Heart Racing / Slowing
- [ ] Other:

RESPIRATORY
- [ ] Short of breath - Constant
- [ ] Short of breath - Exertion
- [ ] Wheeze
- [ ] Air hunger / yawn
- [ ] Frequent Sighs
- [ ] Upper Resp Infx
- [ ] Asthma
- [ ] Other:

SLEEP
Quality of Sleep:
- [ ] None [ ] Poor [ ] Good [ ] Great
- [ ] Hours in bed
- [ ] Hours asleep
- [ ] Interrupted x per night
- [ ] Waking at am
  - [ ] Difficulty falling asleep
  - [ ] Difficulty staying asleep
  - [ ] Crave sleep during day
  - [ ] Awaken Suddenly (Jolt)
  - [ ] Don't dream
  - [ ] Nightmares / Epic dreams
  - [ ] Night sweats
  - [ ] Restlessness
  - [ ] Restless Leg Syndrome

EMOTIONS
- [ ] Sadness / Depression
- [ ] Moodiness / Irritable
- [ ] Frustrated / Angry
- [ ] Nervous / Anxiety
- [ ] Grief
- [ ] Panic / Fear
- [ ] Cry
- [ ] S.A.D.
- [ ] OCD
- [ ] Other:

HEADACHES
- [ ] Base of Skull (back)
- [ ] Side of Head (temples)
- [ ] Frontal (above eyes)
- [ ] Top of Head
- [ ] Entire Head
- [ ] Migraines

COGNITION
- [ ] Forget Names
- [ ] Forget Numbers
- [ ] Forget Words
- [ ] Forget Actions
- [ ] Difficulty Concentrating
- [ ] Other:

ENERGY
- [ ] Norm [ ] Low [ ] Variable [ ] High
- [ ] Slow to start in am
- [ ] Low energy after meals
- [ ] Energy crash at ___ am/pm
- [ ] Other:

URINATION
Times during the night
- [ ] Urgency
- [ ] Burning/Pain
- [ ] Odor/Foamy
- [ ] Dark color
- [ ] Incontinence
- [ ] Urinary tract infection
- [ ] Kidney troubles
- [ ] Other:

MALE ONLY
- [ ] Erectile Dysfunction
- [ ] Prostate Problems
  - [ ] Burn
  - [ ] Achy / Pain
  - [ ] Restriction / Swelling
- [ ] Other:

FEMALE ONLY:
Date Last Period:
Cycle Length (28-30 days):
Number of Days of Flow:
Cramps:
[ ] mild [ ] mod [ ] severe
PMS: [ ] mild [ ] mod [ ] severe
- [ ] Vaginal Itching / Discharge
- [ ] Heavy flow
- [ ] Large clots
- [ ] Yeast Infection
- [ ] Menopause
- [ ] Hot Flashes
- [ ] Vaginal Dryness
- [ ] Painful Intercourse
- [ ] Other:

OTHER HEALTH EVENTS / ISSUES: