New Patient Application and Case History (Auto-Immune)

Name _____ Age _____ Sex: M F DOB _____ Today's Date _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Height _____ Weight: _____ Employer _____ Occupation _____ Length of Employment _____

Present Complaints

1. What have you been diagnosed with? Year first diagnosed ?
   (1) _____ _____
   (2) _____ _____
   (3) _____ _____
   (4) _____ _____

2. Symptoms (list all):
   _____
   _____
   _____
   _____
   _____

3. Severity of problem (circle):
   Minimal (annoying but causing no limitation)
   Slight (tolerable but causing a little limitation)
   Moderate (sometimes tolerable but definitely causing limitation)
   Severe (causing significant limitation)
   Extreme (causing near constant limitation (>80% of the time))

4. What types of treatment have you received:
   Prescription/Drug therapy_____
   Nutritional _____
   Alternative/Holistic _____

5. List your health goals in order of Importance:
   _____
   _____
   _____
   Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

6. What are you hoping happens today as a result of your consultation:
   _____
   _____

7. How often are you aware of your main problem (circle one):
   Occasionally (25% of the time) Frequently (75% of the time)
   Intermittently (50% of the time) Constantly (100% of the time)

Medications

(List all prescription, over-the-counter, **botanicals, homeopathic, and supplements**)

_____ _____
_____ _____
_____ _____

Medical and Social History

Surgeries/Hospitalizations Date

_____
_____
_____

Trauma Date

_____
_____
_____

Past/Recent Illness Date

_____
_____

Marital Status: S/ M/ W/Sep./D Spouse _____

Children / ages:

_____

Family History (mother, father, siblings, spouse, children) Date

_____
_____

Do you use: Alcohol Y N Tobacco Y N Caffeine Y N

___ drinks/week ___ pack/day ___ cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL

P C Fatigue
P C Recent weight change
P C Fever

EYES

P C Blurred/double vision
P C Glasses/contacts
P C Eye disease or injury

EAR/NOSE/MOUTH/THROAT

P C Swollen glands in neck

OTHER

P C Hearing loss or ringing
P C Earaches or drainage
P C Chronic sinus problems or rhinitis
P C Nose bleeds
P C Mouth sores / Bleeding gums
P C Bad breath / bad taste
P C Sore throat or voice change

CARDIOVASCULAR

P C High or Low Blood Pressure
P C Shortness of breath walking/lying
P C Heart disease
P C Chest pain or angina pectoris
P C Palpatation
P C Mitral Valve Prolapse
P C Feet or ankle swelling
P C Shortness of breath
P C Spitting up blood

PSYCHIATRIC

P C Insomnia
P C Memory loss or confusion
P C Nervousness
P C Depression

GENITOURINARY

P C Frequent urination
P C Burning or painful urination
P C Blood in urine
P C Change in force or strain urinating
P C Kidney stones
P C Sexual difficulty
P C Male : testicle pain
P C Female: pain / irregular periods
P C Female: pregnant
P C Bladder Infections
P C Kidney Disease

P C Hemorrhoids

GASTROINTESTINAL

P C Abdominal pain
P C Nausea or Vomiting
P C Rectal bleeding/blood in stool
P C Painful bm / constipation
P C Ulcer
P C Change in bowel movement
P C Frequent diarrhea
P C Loss of appetite

RESPIRATORY

P C Chronic or frequent cough
P C Spitting up blood
P C Pneumonia / Bronchitis
P C Shortness of breath
P C Wheezing
P C Asthma

ENDOCRINE

P C Glandular or hormone problem
P C Excessive thirst or urination
P C Heat or cold intolerance
P C Skin becoming dryer
P C Change in hat or glove size
P C Diabetes
P C Thyroid Disease

MUSCUOSKELETAL

P C Back pain
P C Joint pain

P C Joint stiffness and swelling
P C Muscle pain or cramps
P C Muscle or joint weakness
P C Difficulty walking
P C Cold extremities

INTEGUMENTARY (skin, breast)

P C Change in skin color
P C Change in Hair or Nails
P C Varicose veins
P C Breast pain / discharge
P C Breast lump
P C Hives or Eczema
P C Rash or itching

NEUROLOG ICAL

P C Freq./ recurring headaches
P C Migraine headache
P C Convulsions or seizures
P C Numbness or tingling
P C Tremors
P C Paralysis
P C Head injury
P C Light headed or dizzy
P C Stroke

HEMATOLOGIC/LYMPHATIC/

P C Slow to heal after cuts
P C Easy bleeding or bruising
P C Anemia
P C Phlebitis
P C Past transfusion
P C Enlarged glands
P C Blood or Plasma Transfusions
P C Hepatitis
P C Cancer
P C Infectious Mono
P C AIDS or HIV+
P C Venereal
P C Chicken pox

ALLERGIES / OTHER (drugs, food, or environmental) _____

_____

_____

RECENT TESTS (lab work, x-rays, CT, MRI) _____

_____

_____

OTHER PROVIDERS

_____

_____