EAST WEST COLLEGE OF NATURAL MEDICINE

Initial Visit: Patient Medical Record

Name		Phone	Preferred method of contact
Street Address		Email Address	
City		Emergency Contact Name: _____	
State	Zip	Phone Number(s): _____	
Date of Birth	Occupation	Relationship: _____	
Physician Phone Number		Referred By / How did you hear about us?	
Age	Height	Weight	Gender
Main Problem and when it began			
Other Concurrent Therapies			

Family History of Illness

Place a check in the box if you or any family members have had the following illnesses. If you have had the illness yourself, please indicate the date(s) when your illness occurred.

Disease	Yourself	Father	Mother	Sibling	Grandparent
Cancer					
Diabetes					
High blood pressure					
Heart disease					
Hepatitis B and/or C					
Asthma					
Thyroid disease					
Seizures					
Rheumatic fever					
HIV/AIDS					

Personal Medical History: Complete the information requested below

Surgeries that you have had; when?	
Significant accidents/trauma (car, falls) when?	
Occupational Stresses (chemical, physical psychological stresses)	
Exercise (# times a week, type, how long)	

Daily Diet: Please indicate your average/normal meal for each of the following

Morning	Afternoon	Evening

Medications, Herbals, and Nutraceuticals (List those that you have taken in the last two months)
It is essential to disclose all supplements & medicines, both prescription & over the counter which you are taking

Allergies: List all allergies to drugs, chemicals, foods etc.

Habits: Please indicate how often you consume/use the following:(i.e. 1 pack/day, 3 cups /day, twice a week)

☐ Cigarettes _____	☐ Cola _____	☐ Tea _____
☐ Alcohol _____	☐ Coffee _____	☐ Recreational drugs _____

Please check all that apply:

Appetite & Thirst	Temperature	Sleep	Perspiration	Musculoskeletal
☐ Lack of appetite	☐ Cold hands	☐ Fatigue	☐ Sweat easily	☐ Arthritis
☐ Insatiable appetite	☐ Cold feet	☐ Restless sleep	☐ Sweaty hands	☐ Bursitis
☐ Change in appetite	☐ Cold back	☐ Sleep soundly	☐ Sweaty feet	☐ Osteoporosis
☐ Cravings	☐ Cold abdomen	☐ Insomnia	☐ Cold sweats	☐ Parkinson's disease
☐ Change in thirst	☐ Chills	☐ Wakes often	☐ Night sweats	☐ Tremors
☐ Strong thirst; Prefer cold drinks	☐ Fevers	☐ Difficulty falling asleep	☐ Day sweats	☐ Herniated disks
☐ Strong thirst, Prefer hot drinks	☐ Warm hands	☐ Difficulty waking		☐ Fractures, where?
	☐ Warm feet	☐ Dream disturbed sleep		

Head	Eyes	Ears	Nose	Mouth & Throat
☐ Concussions	☐ Glasses	☐ Ringing in ears	☐ Nose bleeds	☐ Excessive saliva
☐ Facial pain	☐ Eye pain	☐ Earaches	☐ Nasal congestion	☐ Dry mouth
☐ Vertigo	☐ Cataracts	☐ Ear infections	☐ Hay fever/allergies	☐ Gum problems
☐ Migraines	☐ Glaucoma	☐ Hard of hearing	☐ Sinus problems	☐ Bad breath
☐ Headaches (when and where)	☐ Night blindness	☐ Hearing aid	☐ Nasal polyps	☐ Grinding teeth
	☐ Red eyes		☐ Trouble breathing through nose	☐ Teeth problems
	☐ Blurry vision			☐ Jaw clicks
☐ Other head or neck problems?	☐ Double vision			☐ Lip sores
	☐ Tunnel vision (see center of field)			☐ Tongue sores
	☐ Flashes of light/ specks in vision			☐ Dry throat
	☐ Dry eyes			☐ Recurrent sore throats
				☐ Feeling of fullness

				in throat

Please check all that apply:

Neuro-psychological

☐ Traumatic brain injury	☐ ADD, ADHD	☐ Epilepsy
☐ Concussion	☐ Schizophrenia	☐ Lyme's disease
☐ Poor memory	☐ Bipolar	☐ Easily stressed
☐ Autism	☐ Seasonal affective disorder	☐ Anxiety
☐ Obsessive compulsive disorder	☐ Chemical dependency	☐ Depression
☐ Sensory processing disorder	☐ Post traumatic stress syndrome	☐ Considered/attempted Suicide
☐ Difficulty focusing		

Respiratory

☐ Hay fever/allergies	☐ Asthma
☐ Coughs	☐ Chronic bronchitis
☐ Dry cough	☐ Emphysema
☐ Cough with blood	☐ Pneumonia
☐ Cough with phlegm	☐ Shortness of breath
☐ Phlegm Color: _____	☐ Difficulty breathing
☐ Other lung problems _____	☐ Difficulty breathing on exertion

Cardiovascular

☐ Pacemaker	☐ Blood clots
☐ Chest pain	☐ Anemia
☐ Rib Pain	☐ Phlebitis
☐ High blood pressure	☐ Edema
☐ Low blood pressure	☐ Swollen hands/feet
☐ Fainting	☐ Swollen lymph nodes
☐ Palpitations/irregular beat	☐ Other information
☐ Heart attack	_____
☐ Congestive heart failure	_____

Skin and Hair

☐ Rashes	☐ Dandruff
☐ Hives	☐ Loss of hair
☐ Itching	☐ Lumps
☐ Easy bruising	
☐ Pimples/acne	<u>Change in texture or appearance of</u>:
☐ Eczema	☐ Nails
☐ Psoriasis	☐ Hair
☐ Ulceration	☐ Skin
☐ Slow healing sores	☐ Mole/wart(s)

Gastrointestinal System

☐ Heartburn regularly	☐ Distended feeling? Where?
☐ Heartburn at night	☐ Side rib area
☐ Belching	☐ Abdominal area
☐ Indigestion regularly	☐ Diarrhea
☐ Problem w/ certain foods? Which foods? _____	☐ Constipation
_____	☐ Regular laxative use
☐ Gas	☐ Recent change in bowel habits?
☐ Rectal pain	<u>Bowel Movements</u>
☐ Hemorrhoids	_____loose stools
☐ Vomiting	_____frequency
☐ Nausea	_____color (black?)
☐ Sensitive abdomen	_____blood in stools
☐ Pain or cramps	_____texture/formed

Genitourinary

☐ Pain on urination	☐ Blood in urine	☐ Genital warts (HPV)
☐ Unable to hold urine	☐ Frequent urinary tract infections	☐ Prostate enlargement
☐ Frequent urination	☐ Kidney Stones	☐ Impotency
☐ Difficulty urinating	☐ Wake up at night to urinate; how often? _____/night; time _____	☐ Masses, change in testicles
☐ Urgency to urinate		☐ Sexually transmitted disease

Please check all that apply:

Pregnancy & Gynecology

Are you currently pregnant or may be pregnant? ☐ YES ☐ NO

☐ Age at first menses	☐ Breast lumps	☐ Pregnancies, how many
☐ Length of period (days)	☐ Menopause	☐ Number births
☐ Date of last menses _____	☐ Discharge from nipple	☐ Miscarriages
Duration of flow _____	☐ Vaginal dryness	☐ Premature births
☐ Irregular periods	☐ Vaginal sores	☐ Infertility
☐ Heavy flow	☐ Date of last PAP _____	☐ Birth control
☐ Very painful periods	☐ Vaginal discharge	Type of birth control _____
☐ Skipped periods	Describe the vaginal discharge:	_____
☐ Clots in flow	_____	

Pain & Stiffness

☐ Neck pain	☐ Shoulder pain	☐ Pain in fingers
☐ Neck stiffness	☐ Knee pain	☐ Hip pain
☐ Back pain	☐ Elbow pain	☐ Other _____

On the diagram below, please indicate the areas in which you commonly feel pain.

You may circle the area and/or color it in for pain.