Annapolis Healing

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Initial Visit: Patient Medical Record

Name			Home Phone	Cell Phone
Occupation	Company		Email Address	
Street Address			Emergency Contact Name:	
City	State FL	Zip	Phone Number(s):	Relationship
Age DOB		Height _____ ft _____ in	Weight	Male ☐ Female ☐
Physician		Phone Number	Referred By	
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(s)	Grandparent(s)
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)	

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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
_____	☐ Dry eyes			☐ Jaw clicks
_____	☐ Blurry vision			☐ Lip sores
_____	☐ Double vision			☐ Tongue sores
	☐ Tunnel vision (see center of field)			☐ Dry throat
	☐ Flashes of light / specks in vision			☐ Recurrent sore throats
				☐ Feeling of fullness in throat

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Neuro-psychological

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

Respiratory

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

Cardiovascular

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

Skin & Hair

- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Easy bruising
- ☐ Pimples/acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Ulceration
- ☐ Slow healing sores
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Lumps

  Change in texture or <u>appearance of:</u>
- ☐ Nails
- ☐ Hair
- ☐ Skin
- ☐ Mole/wart(s)

Gastrointestinal System

- ☐ Heartburn regularly
- ☐ Heartburn at night
- ☐ Belching
- ☐ Indigestion regularly
- ☐ Problem w/ certain foods?
  Which foods? _____
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Vomiting
- ☐ Nausea
- ☐ Sensitive abdomen
- ☐ Pain or cramps
- ☐ Distended feeling? Where?
  - ☐ Side rib area
  - ☐ Abdominal area
- ☐ Diarrhea
- ☐ Constipation
- ☐ Regular laxative use
- ☐ Recent change in bowel habits?

<u>Bowel Movements</u>

_____ loose stools
_____ frequency
_____ color (black?)
_____ blood in stools
_____ texture/formed

Genitourinary

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

Pregnancy & Gynecology

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

Age at first menses
Length of period (days) _____
Date of last menses _____
Duration of flow

- ☐ Irregular periods
- ☐ Heavy flow
- ☐ Very painful periods
- ☐ Skipped periods
- ☐ Clots in flow
- ☐ Breast lumps
- ☐ Menopause
- ☐ Discharge from nipple
- ☐ Vaginal dryness
- ☐ Vaginal sores
  Date of last PAP _____
- ☐ Vaginal discharge
  Describe the vaginal discharge: _____
- ☐ Pregnancies, how many _____
  Number births _____
- ☐ Miscarriages
- ☐ Premature births
- ☐ Infertility
- ☐ Birth control
  Type of birth control _____

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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.