



# Annapolis Healing

## Initial Visit: Patient Medical Record

Name			Home Phone		Cell Phone	
Occupation		Company		Email Address		
Street Address				Emergency Contact Name:		
City		State	Zip	Phone Number(s):		Relationship
Age		DOB	Height _____ ft _____ in	Weight		Male      Female
Physician		Phone Number		Referred By		
<i>Main Problem and when it began</i>						
Other Concurrent Therapies						

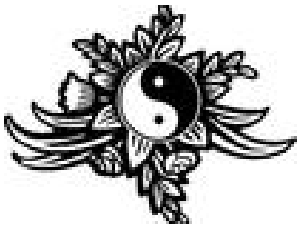
### Family History of Illness

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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<b>Daily Diet:</b> Please indicate your average/normal meal for each of the following		
<b>Morning</b>	<b>Afternoon</b>	<b>Evening</b>
<b>Medications, Herbals, and Nutraceuticals</b> (List those that you have taken in the last two months)		
<i>It is essential to disclose all supplements &amp; medicines, both prescription &amp; over the counter which you are taking</i>		
<b>Allergies:</b> List all allergies to drugs, chemicals, foods etc.		
<b>Habits:</b> 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 Insatiable appetite Change in appetite Cravings Change in thirst Strong thirst; Prefer cold drinks Strong thirst: Prefer hot drinks	Cold hands Cold feet Cold back Cold abdomen Chills Fevers Warm hands Warm feet	Fatigue Restless sleep Sleep soundly Insomnia Wakes often Difficulty falling asleep Difficulty waking Dream disturbed sleep	Sweat easily Sweaty hands Sweaty feet Cold sweats Night sweats Day sweats	Arthritis Bursitis Osteoporosis Parkinson's disease Tremors Herniated disks Fractures, where?
Head	Eyes	Ears	Nose	Mouth & Throat
Concussions Facial pain Vertigo Migraines Headaches (when and where)	Glasses Eye pain Cataracts Glaucoma Night blindness Red eyes Dry eyes Blurry vision Double vision Tunnel vision (see center of field) Flashes of light / specks in vision	Ringing in ears Earaches Ear infections Hard of hearing Hearing aid	Nose bleeds Nasal congestion Hay fever/allergies Sinus problems Nasal polyps Trouble breathing through nose	Excessive saliva Dry mouth Gum problems Bad breath Grinding teeth Teeth problems Jaw clicks Lip sores Tongue sores Dry throat Recurrent sore throats Feeling of fullness in throat



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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		Cardiovascular	
Hay fever/allergies	Asthma	Pacemaker	Blood clots
Coughs	Chronic bronchitis	Chest pain	Anemia
Dry cough	Emphysema	Rib Pain	Phlebitis
Cough with blood	Pneumonia	High blood pressure	Edema
Cough with phlegm	Shortness of breath	Low blood pressure	Swollen hands/feet
Phlegm	Difficulty breathing	Fainting	Swollen lymph nodes
Color:	Difficulty breathing on exertion	Palpitations/irregular beat	Other information
Other lung problems		Heart attack	
		Congestive heart failure	
Skin & Hair		Gastrointestinal System	
Rashes	Dandruff	Heartburn regularly	Distended feeling? Where?
Hives	Loss of hair	Heartburn at night	Side rib area
Itching	Lumps	Belching	Abdominal area
Easy bruising		Indigestion regularly	Diarrhea
Pimples/acne	Change in texture or appearance of:	Problem w/ certain foods? Which foods?	Constipation
Eczema	Nails		Regular laxative use
Psoriasis	Hair	Gas	Recent change in bowel habits?
Ulceration	Skin	Rectal pain	
Slow healing sores	Mole/wart(s)	Hemorrhoids	<u>Bowel Movements</u>
		Vomiting	loose stools
		Nausea	frequency
		Sensitive abdomen	color (black?)
		Pain or cramps	blood in stools
			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	
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			



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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.

