IRIE NATURAL HEALTH CENTER
Feeling good the natural way
6625 S Rural Rd., #103, Tempe, Az 85283
480-341-9400 Fax 1-623-321-0219

GENERAL HEALTH HISTORY

PATIENT INFORMATION:			
Name		Date	
Address			
City, Zip			
Email		Cell	
Height	Weight	DOB	Age

LIST IN ORDER OF IMPORTANCE WHAT YOUR PROBLMES ARE:	DATE PROBLEM BEGAN
1.	
2.	
3.	

ACCIDENT INFORMATION:

Is your condition due to an accident? □No □ Yes Date:_____ Type of accident? □ Automobile □ Work □ Home □ Other_____

MEDICATIONS: (All medication including aspirin, OTC or vitamin supplements)	DOSAGE	HOW OFTEN TAKEN

PATIENT CONDITION

1. Have you had this problem before? □ Yes □ No
2. Is your condition getting progressively worse? □ Yes □ No
3. Is the problem: □ Constant □Comes and goes □ worse in am □ worse in pm □stiffness am or pm
4. How does it feel? □ Burning □ Sharp □ Shooting □ Dull □Aching □ Stiff □ Tingling □ Throbbing □ □ Swelling □knifelike □ excruciating □numbness □ pins and needles □ Bone pain □ Other
5. Joint noises? □clicking □grinding □popping □locking □swelling?

Circle below the severity of your current pain on a scale of 0-10

(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

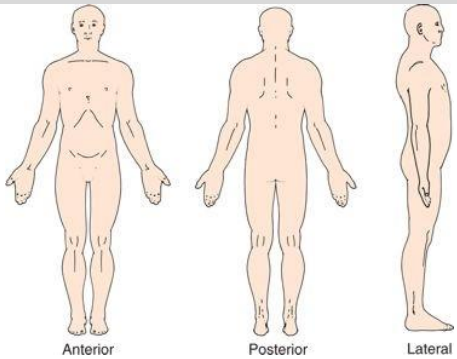
Circle below the *maximum severity* of pain experienced on a scale of 0-10

(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

1. What makes your condition better? _____
2. What makes your condition worse? _____

3. **Does your condition interfere with your** □ Work □ Sleep □Daily Routine □Recreation □ Sports □Hobbies □ Other
4. **What activities/movements are painful to perform:** □Sitting □Standing □Walking □Bending □ Lying down □ Getting up □Turning neck/ trunk □ When still or moving □ driving
5. **What treatment or therapies have you have tried?** □ Diet □ Fasting □ Vitamins/minerals □ Herbs □ Homeopathy □ Chiropractic □ Acupuncture □ Conventional drugs □ Physical therapy □ Pain injections □Chemotherapy □Radiation Therapy □ Other_____
   Did it help? Y/N _____

Place mark where it hurts



Mark or circle where it hurts or problem area.

Do you experience any of these general symptoms EVERY DAY?

□ Panic attacks □ Shortness of Breath □ Insomnia □ Constipation □ Chronic pain/inflammation
□ Bleeding □ Depression □ Debilitating fatigue □ Nausea □ Fecal incontinence □ Poor wound healing
□ Dizziness □ Disinterest in sex □Vomiting □ Urinary Incontinence □ Low grade fever □ Itching/rash

Any recent laboratory procedures performed (blood, stool, urine, etc) □ Y □N
Outcome or Results_____

PAST HEALTH HISTORY

Have you been diagnosed with □ Cancer □ High Blood Pressure □ Diabetes Kidney disorder □ Liver disorder
Any Surgeries related to current issue? □Yes □ No What year: _____
Any major accidents?□ Y □N What year: _____
Any fractures? ?□ Y □N What location_____ What year: _____
Have you had any imaging □ X-rays □ MRI □ CT □ Ultra Sound □ LABs results: □ Normal or □Abnormal
When was you last blood work? _____
Any Allergies to medication? □ Y □N What medication? _____
Sulfa Allergies □ Y □N Latex allergies □ Y □N
Any seizure history? □ Y □N □Antacids □Steroids □Hormone Replacement therapy
Recreational Drugs? □ Y □N Any Drug Addiction? □ Y □N Any Drug Treatment? □ Y □N
Are you taking any opioid medication (Percocet, Opana, Hydrocodone etc) that you would like to stop? □ Y □N
Are you currently taking anticoagulants such as Aspirin, Warfarin or Coumadin? □ Y □N

Major Hospitalizations, Surgeries, Injuries. Please list all procedures, complication (if any) and dates

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (eg work, finances, relationship(s) etc) _____
What is your overall energy level on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Do you sleep through the night? Y □N Do you wake rested? □ Y □N
Do you consider yourself: □ underweight □ overweight □ just right
Your weight today_____lbs Your weight at age 20_____lbs Your ideal weight_____lbs
Have you had unintentional weight loss or gain of 10 pounds or more in the last three months? □ Y □N
What is your nutrition and diet like? □Mixed food diet (animal and vegetable source) □Vegetarian □Vegan
What are your eating habits? □ One meal per day □Two meals per day □Three meals per day □Graze (small frequent meals) □Eat constantly whether hungry or not □Caffeine (coffee, pop, etc) □ Laxative use
Glasses of water/day____ Cups of coffee per day _____ Energy Drinks (Monsters/RedBull) per day_____
Exercise history: □None □1 to 2 days per week □ 3 to 4 days per week □ 5 to7 days per week
□Less than 45 minutes per workout □ More than 45 minutes per workout
How committed are you to making a change in your health (1=least, 10=most committed):1 2 3 4 5 6 7 8 9 10
Do you tend to be sensitive to medications? □ Y □N
Are you particularly sensitive to perfumes, gasolines, or other vapors? □ Y □N
Do you use pesticides, herbicides or other chemical around you home? □ Y □N

SOCIAL HEALTH HISTORY

Marital Status □Single □Partner □Married □Separated □Divorced □Widow(er)
Number of children?_____
Do you smoke cigarettes? □ Y □N #per day _____ Former Smoker? □
Do you drink alcohol? □ Y □N □ occasionally
Job Position? _____ Do your job duties include □ desk job □ standing □ lifting □stooping□ kneeling □ twisting of body□ turning of neck □ bending neck.
Do job duties involve, lifting up to____lbs x ___per week
How many hours a night do you sleep? _____ Does your pain interfere with your sleep?□Yes □No
Excessive worry? □ Y □N Racing Thoughts? □ Y □N Anger/Irritability? □ Y □N High-strung/Tense□ Y □N
Do you feel anxious? □ Y □N Depressed? □ Y □N Panic Attacks? □ Y □N
Nightmares □ Y □N Reliving traumatic events (flash backs)□ Y □N Hypervigilance□ Y □N
Fear in crowd's □ Y □N Thoughts of Suicide □ Y □N Are you taking any psych meds? □ Y □N
Any history of sexual abuse, mental, emotional or physical abuse? □ Y □N
Cannabis Experience: □New □Moderate □Experienced

ORGAN SYSTEM REVIEW- DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)
Check all that Apply □ Arthritis □ Allergies/hay fever □ Asthma □ Alcoholism □ Alzheimer's disease □ Autoimmune disease □ Blood pressure problems □ Bronchitis □ Cancer □ Chronic fatigue syndrome □ Carpal tunnel syndrome □ Chest pain □ Elevated cholesterol □ Circulatory problems □ Dental problems □ Diabetes □ Diverticular disease □ Drug addiction □ Eating disorder □ Epilepsy/seizures □ Emphysema □ Eyes, ears, nose, throat problems □ Environmental sensitivities □ Fibromyalgia □ Food intolerance □ Gastroesophageal reflux disease □ Genetic disorder □ Glaucoma □ Gout □ Heart disease □ Chronic infection □ IBD/colitis □ Irritable bowel syndrome □ Kidney or bladder disease □ Liver or gallbladder disease (stone) □ Mental illness □ Migraine Headaches □ Neurological problems (Parkinson's, paralysis, etc) □ Stroke □ Thyroid problems □ Obesity Osteoporosis □ Pneumonia □ Sexually transmitted disease □ Skin problems □ Tuberculosis □ Ulcer □ Urinary tract infections □ Varicose veins □ HIV
General: □ Chills □ Fever □ Weight loss □ Night sweats □ Night pain □ Am stiffness □ Rashes □ Puffiness □ Poor appetite/decreased appetite □ Chemo related side effects □ Radiation therapy side effects
HEENT □ Ear ringing □ Headaches □ Blurry vision □ Double vision □ glaucoma □ Nasal fractures □ Tooth pain □ Jaw pain □ Vertigo □ Head injury □ Tongue pain □ Macular Degeneration □ Dandruff □ Hair Loss
Musculoskeletal: □ Neck injury □ Back injury □ Back pain □ Neck pain □ Weakness □ Muscle/joint pain or stiffness □ Paralysis □ Limitation of movement □ Arthritis □ Fibromyalgia □ Muscle atrophy □ Muscle spasms □ Joint swelling □ Leg cramps □ Tremors
Cardio: □ Chest pain □ Murmurs □ Cardiac disorder □ High Blood Pressure □ Angina □ Abnormal EKG □ Congestive Heart Failure □ Heart Attack □ Kidney Disorder □ Arrhythmia □ Irregular heart beat □ Ankle swelling □ Palpitations □ Rheumatic Fever
Lungs: □ Shortness of breath □ Asthma □ Respiratory disorder □ Productive cough
Abdomen: □ Heartburn □ Crohn's disease □ Hepatitis C □ Nausea □ Vomiting □ Decreased appetite □ Constipation □ Diarrhea □ Rectal Bleeding □ Bowel dysfunction □ Bladder dysfunction BM's per/day___ Consistency of stools? □ Hard □ Soft □ Marbles □ Normal □ other_____ Any pain with urination? □ Y □ N □ Indigestion □ Bloating □ Excessive belching
Male: □ Benign prostatic hyperplasia □ Prostate cancer □ Testicular cancer □ Decreased sex drive □ Testicular pain/swelling □ Hernia □ Discharge □ Impotency □ Breast enlargement
Female: □ Menstrual irregularities □ Endometriosis □ Infertility □ Fibroid/ovarian cyst □ PMS □ Heavy Bleeding □ Pelvic pain □ Vaginal discharge □ Breast cancer □ Pelvic inflammatory disease □ Vaginal infections □ Decreased sex drive □ Menopause □ Surgical menopause □ C-Section How many____ □ Last Pap exam □ Number of Pregnancies □ pain with intercourse □ Incontinence Age of first period _____ Length of last period_____ Length of cycle ____days Any recent changes in menstrual flow (e.g. Heavier, more clots, etc) Date of last menstrual cycle: _____ Are you pregnant? □ Y □ N
Breast: □ Cancer □ Prior surgery/biopsy □ Fibrocystic breast Last mammogram_____ □ Chemo □ Radiation □ Nausea □ Weight loss □ Pain □ Discharge from nipple
Neuro: □ MS □ Epilepsy □ ALS □ Alzheimer's □ fainting □ dizziness □ numbness □ tingling/burning
I Would like to: □ Feel more vital □ Feel less pain □ Lose weight □ Improve memory □ Be less indecisive □ Increase sex drive □ Use less medication □ Have more endurance □ Sleep better □ Be stronger □ Be less moody □ Feel more motivated □ Increase muscle tone □ Slow down aging □ Other_____