Earth Integrated Medicine, LLC

It's About Options

Name:_____ Date:_____/_____/_____

Birth Date: _____/_____/_____ Age:_____ Gender: M / F

Marital Status: Single Married Divorced Partnership Widowed

Number of Children: _____Ages:_____

Address: _____ City: _____State: _____

Phone: _____ Cell: _____ Other: _____

Occupation: _____ Employer: _____

Who may we thank for your referral? _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

CHIEF COMPLAINT:

_____

History of Present Illness:Location of pain or problem:

_____

When did it Start_____

Describe severity and duration: _____

Anything make it better or worse: _____

Since the onset of the problem, do you feel your condition is improving or deteriorating?

_____

_____

Any other symptoms that are coinciding with this condition?

_____

_____

MEDICAL HISTORY

NAME:_____

TOBACCO USE: YES/NO HOW MUCH?_____ RECREATIONAL DRUGS?_____
HOW OFTEN DO YOU CONSUME ALCOHOLIC BEVERAGES? _____
CAFFEINE CONSUMPTION?_____
DO YOU EXERCISE_____
EXPOSURES TO: ___PAINT ___SOLVENTS ___CHEMICALS___DUST ___NOISE___OTHER
CURRENT MEDICATIONS:_____

_____

KNOWN ALLERGIES:_____

_____

(FEMALES) ARE YOU PREGNANT? YES NO

PAST ILLNESS OF YOURSELF AND FAMILY

YOU/YOUR FAMILY

- ☐ ☐ALCOHOLISM
- ☐ ☐ ANEMIA
- ☐ ☐ ASTHMA
- ☐ ☐ ANXIETY/DEPRESSION
- ☐ ☐ CANCER/TUMOR
- ☐ ☐ DIABETES
- ☐ ☐ DRUG ABUSE
- ☐ ☐ DEPRESSION
- ☐ ☐ EPILEPSY/SEIZURES
- ☐ ☐ GLAUCOMA
- ☐ ☐ GENETIC DISEASES
- ☐ ☐ HEART DISEASE
- ☐ ☐ HIGH BLOOD PRESSURE
- ☐ ☐ HIGH CHOLESTEROL
- ☐ ☐ KIDNEY DISEASE

YOU/YOUR FAMILY

- ☐ ☐ HEPATITIS
- ☐ ☐ LUNG DISEASE
- ☐ ☐ MENTAL ILLNESS
- ☐ ☐ OSTEOARTHRITIS
- ☐ ☐ OSTEOPOROSIS
- ☐ ☐ PHLEBITIS
- ☐ ☐ RHEUMATOID ARTHRITIS
- ☐ ☐ STROKE
- ☐ ☐ SUICIDE ATTEMPT
- ☐ ☐ THYROID DISEASE
- ☐ ☐ TUBERCULOSIS
- ☐ ☐ ULCER IN GI TRACT
- ☐ ☐ VENEREAL DISEASE
- ☐ ☐ HIV/AIDS
- ☐ ☐ OTHER _____

PAST SURGICAL HISTORY:

GENERAL	NOW	PAST
Weight Gain or Loss	☐	☐
Fever	☐	☐
Chills	☐	☐
Fatigue/Weakness	☐	☐
Sweats/ Night Sweats	☐	☐
Sleep Trouble/ Insomnia	☐	☐

EENT	NOW	PAST
Earaches/Infections	☐	☐
Ringing/Noise	☐	☐
Difficult/Loss of Hearing	☐	☐
Allergies/runny nose	☐	☐
Congestion/Post Nasal Drip	☐	☐
Loss of Smell or Taste	☐	☐
Cold Sores/Blister	☐	☐
Canker Sores	☐	☐
Bleeding Gums	☐	☐
Grinding Teeth	☐	☐
Difficulty Chewing	☐	☐
Difficulty Swallowing	☐	☐
Sore Throats or Tonsillitis	☐	☐
Swollen Lymph Glands	☐	☐

EYES	NOW	PAST
Corrective Eye Lenses	☐	☐
Blurry/Double Vision	☐	☐
Burning/Red or Itchy Eyes	☐	☐
Eye pain	☐	☐
Styes	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

SKIN & HEAD	NOW	PAST
Acne	☐	☐
Hives or Rashes	☐	☐
Lesions or Sores	☐	☐
Eczema	☐	☐
Psoriasis	☐	☐
Dry or Scaly Skin	☐	☐
Skin Discoloration	☐	☐
Easy Bruising	☐	☐
Itching	☐	☐

RESPIRATORY	NOW	PAST
Chest Pain	☐	☐
Cough	☐	☐
Cough Blood	☐	☐
Pneumonia	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐

CARDIOVASCULAR	NOW	PAST
Murmur	☐	☐
Palpitations	☐	☐
Shortness of Breath	☐	☐
Hands and Feet Turning Blue	☐	☐
Stroke	☐	☐
MI	☐	☐
Swelling Ankles	☐	☐
Chest Pain	☐	☐

ENDOCRINE	NOW	PAST
Heat/Cold Intolerance	☐	☐
Frequent Thirst/Urination	☐	☐
Shakiness/Headache if Misses Meals	☐	☐

NEUROLOGICAL	NOW	PAST
Headaches/Migraines/Dizziness	☐	☐
Numbness/Tingling	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐
Paralysis	☐	☐
Seizures/Epilepsy	☐	☐
Fainting Spells	☐	☐

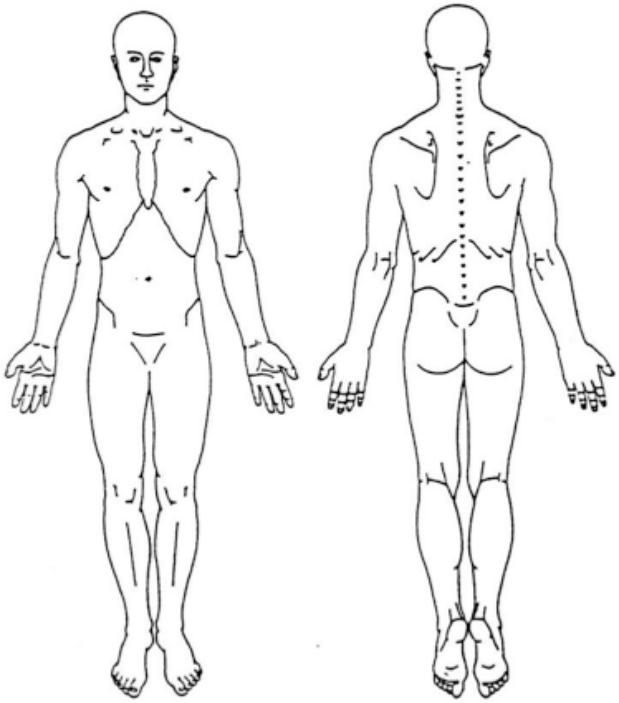
GASTROINTESTINAL	NOW	PAST
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation or Diarrhea	☐	☐
Heaviness After Eating	☐	☐
Black or Bloody Stool	☐	☐
Rectal Pain or Itching	☐	☐
Bloating or Gas	☐	☐
Gallbladder Disorders	☐	☐

UROGENITAL	NOW	PAST
Burning/Urgency/Frequency	☐	☐
Incontinence	☐	☐
Difficulty Urinating	☐	☐
Bloody or Cloudy Urine	☐	☐
Recurrent Infections	☐	☐
History of Stones	☐	☐
Erectile Dysfunction	☐	☐

FEMALE	NOW	PAST
PMS	☐	☐
Irregular Cycles	☐	☐
Heavy or Painful Periods	☐	☐
Vaginal Dryness, Pain or Itching	☐	☐
Menopausal Symptoms/Hot Flashes	☐	☐
Diminished or Excessive Sex Drive	☐	☐
Painful or Swollen Breasts	☐	☐
Lumps in Breast or Nipple Discharge	☐	☐

MUSCULOSKELETAL	NOW	PAST
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
Neck Pain	☐	☐
Joints Pop or Crack Easily	☐	☐
Leg Cramps	☐	☐
Restless Legs	☐	☐
CarpelTunnel	☐	☐

Please draw on diagram where you have symptoms:



Any other questions or concerns?

_____

_____

List the specific goals you'd like to accomplish during our time together:

_____

_____

Now describe the level of health you'd like to be experiencing one year from today:

_____

_____