

Center of Health
17440 Dallas Parkway #232
Dallas, TX 75287
Ph: 972-248-9083
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Client Information

Date: _____

Client Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Height: _____ **Weight:** _____ **Date of Birth:** _____

Occupation: _____

Partner Status: _____

In Emergency Notify: _____ **Phone number:** _____

Referred By: _____

Family Physician: _____

Cancellation Policy:

Cancellations must be made 48 hours before scheduled appointment to avoid being charged for the full office visit

Please initial

Medical History

Name: _____ Sex _____ Weight _____ Height _____

Religion _____ Occupation _____

Present Complaint _____ Onset _____

Health Care providers you are seeing	Specialty	Diagnosis

Have you been Exposed to toxic chemicals? _____

If so which ones _____

WOMEN (next two lines):

Age at onset of Menstruation: ____ # of Children: ____ # of miscarriages/c-sections: ____

Age at onset of Menopause: ____ Date of last period: _____

Health as a child? (circle one) Excellent Good Fair Poor

Were there any complications with YOUR delivery? Please explain: _____

Were you breast-fed? ____ How long? _____

Did you have any serious emotional/mental traumas as a child? Please explain? _____

Circle diseases for which you have been immunized:

Measles Mumps Rubella Smallpox Influenza Tetanus Diphtheria

Other: _____

Blood Type: A B AB O Don't Know

Serious Illness/Injuries/Surgeries	Date	Outcome

Allergies/Sensitivities (please specify)	Typical Reaction
Animal hair/dander:	
Chemicals:	
Drugs/Medications:	
Dust/Mold:	
Foods:	
Grass/Weeds/Pollen:	
Other:	

TEST HISTORY:

Please List the date of your most recent procedures. *Circle any tests that were abnormal.*

Test	Year	Test	Year	Test	Year	Test	Year
Chest x-ray		TB test		Pap Smear		Other:	
Kidney x-ray		EKG		Mammogram			
GI series		MRI		Sigmoidoscopy			
Colon x-ray		Cardiac Stress Test		PSA			
Spine x-ray		CAT Scan		Rectal Exam			
Blood test		Cholesterol		Complete Physical			

Health Habits:

Please list ALL supplements, herbs, homeopathic you are currently taking (attach a separate sheet if necessary):

Type (include brand name)	Dose

Please circle any of the following medications you are currently taking or have taken within the last 3 months:

Allergy Medication	Anti-Inflammatory	Antibiotics/ Anti-fungal	Antidepressants
Anti-diabetic/insulin	Chemotherapy	Cortisone	Antacids
Aspirin/Tylenol/Advil	Heart Medication	High Blood Pressure	Hormones
Laxatives	Pain Medication	Oral Contraceptives	Ulcer Medication
Radiation	"Recreational Drugs"	Relaxants	Sleeping Pills
Thyroid	Ulcer Medications	Lithium	Other:

Do you:

(Circle day or week, as appropriate):

Use Tobacco _____ packs per day/week How many years? _____
Drink Coffee _____ cups per day/week
Drink black tea _____ cups per day/week
Drink alcohol _____ cups per day/week
Drink sodas _____ cups per day/week
Use artificial sweeteners _____ packets per day/week
Use Margarine _____ pats per day/week

How many times a week do you eat out Breakfast: _____ Lunch: _____ Dinner: _____

What types of restaurants? _____

What are your favorite foods? _____

Do you crave sweets? _____ At what time? _____ Do you salt your food at the table? _____

Are there other foods you crave? (Please Circle): Bread Pasta Dairy Meat Other: _____

What foods do you REALLY dislike: _____

Are you on any specific diet? If so, please specify: _____

Would you like to increase or decrease your weight? _____ If so, by how much? _____

When did you last have a significant change in weight (more than 10 pounds)? _____

What exercise do you do and how often? _____

How many hours of sleep do you get each night? _____ Do you wake rested? _____

Are you presently sexually active? _____ Any difficulties? _____ Method of BC? _____

Rate your current stress level from 1-10: _____ How much does this affect you (1-10)? _____

What are the major stress factors in your life now? _____

Please rate your current emotional health (please circle): excellent/ good/ fair/ poor/ unstable/ crisis

Are you currently in psychotherapy? _____ Do you have a good support network/team? _____

Does your home environment have a supportive effect on your health? _____

How many hours of relaxation (not sleep) do you give yourself during the workweek? _____

During weekends? _____ Favorite recreational activities? _____

When was your last eye exam? _____ Do you wear contacts? _____ Hard or soft? _____

Do you drink purified or bottled water? _____ What brand? _____

Do you have an air purifier in the room you sleep in? _____ What brand? _____

Do you have amalgam (silver) fillings? _____ Any other dental problems? _____

Do you make an effort to eat organically grown food? _____ What % of your diet? _____

Are you on a restricted diet due to religious or other beliefs (e.g. Hindu, Kosher, Vegan, etc)? _____

Please Explain: _____

Are you considering any elective surgery or medical procedures in the near future? _____

FAMILY HEALTH HISTORY:

Relation	Age	Living/Deceased	Age at death	Check if your relatives have/had Disease Relationship		
<i>Father</i>						
<i>Mother</i>						
<i>Brothers</i>						
<i>Sisters</i>						

Diet Survey:

Please list everything you have eaten for the past 2-3 days:

Day	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

PLEASE **TYPE** A TIME LINE OF YOUR HEALTH
FROM BIRTH TO NOW

Be sure to include any trauma or
significant occurrences