**Carlos Durana, Ph.D., M.Ac.**

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INTAKE FORM - I

**New Client Intake Form** (Please print or write clearly) Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_ ZIP \_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency notify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their Home Phone \_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ ZIP \_\_\_\_\_

Reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_\_\_\_\_ Have you had it in the past? \_\_\_\_\_\_\_

If “yes” in the past, describe when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition… getting worse\_\_\_ getting better\_\_\_ constant\_\_\_ comes and goes\_\_\_

If applicable, circle a number to indicate your level of difficulty.

Minimal = 1 2 3 4 5 6 7 8 9 10 = Extreme

If you have a diagnosis, what is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosing physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any other practitioners treating this condition? Y / N \_\_\_\_\_

Are you under the care of another physician for any other problems? (List problem and physician) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What kinds of treatments have you tried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What was occurring in your life when your difficulties began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any important events occurring at that time or since then that may have started the difficulties of that contribute to them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications, hormones, laxatives, herbs, homeopathics and supplements you are taking and for what reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list allergies to any medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical History

Date of your last physical exam \_\_\_\_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgeries and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Significant accidents, hospitalizations and traumas with dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you or have you ever had (circle and mark year):

|  |  |  |
| --- | --- | --- |
| AIDS, ARC or HIV | Kidney or bladder trouble | Cancer |
| Dyslexia | Thyroid problems | Hepatitis |
| IDADHD | Hemophilia | Liver disease |
| Sexually transmitted disease | Rheumatic fever | Ulcer |
| Epilepsy | Polio | Depression |
| Gallstones | Scarlet fever | Anxiety |
| Sudden weight loss | Neuralgia | Emphysema |
| Blood transfusions | Hemorrhoids | Pneumonia |
| Mononucleosis | Malaria | Eczema |
| Arthritis | Yellow jaundice | Hives/rashes |
| High blood pressure | German measles | Bronchitis |
| High cholesterol | Pancreatitis | Diverticulosis |
| Heart trouble | Tuberculosis |  |



Have you ever taken adrenal corticosteroids (cortisone, prednisone, etc.)? Y / N \_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many courses of antibiotics have you had? \_\_\_\_\_\_\_\_

Do you have silver amalgam fillings? \_\_\_\_\_\_\_\_

Unusual birth history (prolonged labor, forceps delivery, C-section, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_

Please list accidents/surgeries and location of scars \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What inoculations have you had? Tetanus (lockjaw) \_\_\_ Smallpox \_\_\_ Diphtheria \_\_\_

Poliomyelitis \_\_\_ Pertussis (whooping cough) \_\_\_ Rubella (German measles) \_\_\_

Flu \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_

What inoculations have you had in the last year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where have you traveled outside this country? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## \*\*\* Please circle all that apply and list year when occurred \*\*\*

# Family Medical History

|  |  |  |
| --- | --- | --- |
| Alcoholism | Anemia | Liver disease |
| Allergies | Diabetes | Stomach ulcers |
| Arthritis | Epilepsy | Lung disease |
| Gout | Heart disease | Psychological problems |
| Asthma | Glaucoma | Stroke |
| Cancer/tumors | High blood pressure | Genetic diseases |
| Coronary artery disease | Kidney disease |  |



# Musculoskeletal

|  |  |  |
| --- | --- | --- |
| Neck pain/stiffness | Mid back pain/stiffness | Leg or calf cramping |
| Shoulder blade pain | Low back pain/stiffness | Ankle pain/stiffness |
| Shoulder joint pain/stiffness | Sacroiliac pain/stiffness | Numbness or tingling in feet |
| Upper arm pain/stiffness | Hip joint pain/stiffness | Foot or toe pain/stiffness |
| Elbow pain/stiffness | Pain into thigh or upper leg | Weak ankles |
| Wrist pain/stiffness | Pain into calf or lower leg | Muscle spasm |
| Hand or finger pain/stiffness | Weak legs | Muscle weakness |
| Numbness or tingling in hands | Knee pain/stiffness | Paralysis |
| Upper back pain/stiffness | Weak knees | Stiff all over |

Is the problem helped by pressure \_\_\_ heat \_\_\_ cold\_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem aggravated by pressure \_\_\_ heat \_\_\_ cold\_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Gastrointestinal**

|  |  |  |
| --- | --- | --- |
| Constipation | Hemorrhoids | Gurgling noise in stomach |
| Hard stools | Colitis | Bad breath |
| Bowel movements feel incomplete | Diverticulitis | Excessive appetite |
| Frequent laxative use | Parasites | Poor appetite |
| Diarrhea | Abdominal bloating | Excessive thirst |
| Loose stools | Gas (flatulence) | Nausea |
| Erratic bowel movements | Mucous in stool | Vomiting |
| Foul smelling stools | Hiatal hernia | Bloated |
| Undigested food in stool | Lower abdominal pain/cramping | Belching |
| Gained/lost more than 10 pounds | Upper abdominal pain/cramping | Ulcer |
| Blood in stool | Stomach acidity | Difficulty swallowing |
| Black stool | Indigestion |  |

### How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_

### 

### **Cardiovascular**

|  |  |  |
| --- | --- | --- |
| High blood pressure | Coronary heart disease | Edema |
| Low blood pressure | High cholesterol | Swelling of hands |
| Blackouts or fainting | Stroke | Swelling of feet |
| Irregular heartbeat | Blood clot | Cold hands |
| Heart valve problem/murmur | Phlebitis | Cold feet |
| Rapid heartbeat/palpitations | Leg cramps | Hot palms |
| Dizzy spells | Varicose veins | Hot feet or soles |
| Shortness of breath | Bruise easily | Generally too hot |
| Angina or chest pain | Anemia | Generally too cold |

### **Skin and Hair**

|  |  |  |
| --- | --- | --- |
| Rashes | Herpes Zoster (shingles) | Moist feet |
| Hives | Boils | Moist palms |
| Itching | Pimples or acne | Fungus on skin |
| Burning skin | Ulcerations or sores | Fungus under nails |
| Eczema | Recent moles | Weak or brittle nails |
| Psoriasis | Recent change in mole | Loss of hair |
| Bruise easily | Warts | Dandruff |
| Bleed easily | Dry skin |  |



### Any numb areas? \_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Eyes**

|  |  |  |
| --- | --- | --- |
| Nearsighted (myopia) | Night blindness | Watery eyes |
| Farsighted (hyperopia) | Sensitivity to light | Itchy eyes |
| Astigmatism | Blurred vision | Red eyes |
| Glaucoma | Floating spots | Conjunctivitis |
| Cataracts | Pressure behind eyes | Use eyeglasses or contacts |
| See halo | Eye pain | Blindness |
| See double | Dry eyes | Eye infections |

### **Sleep**

|  |  |  |
| --- | --- | --- |
| Difficulty falling asleep, wired | Wake at night—mind empty, eyes open | Need to take naps |
| Shallow sleep | Snoring | Sleep too much |
| Dream disturbed sleep | Wake up unrefreshed | Sleep too little |
| Nightmares | Sleepy in the afternoon | Sleep on a waterbed |
| Wake at night—thinking | Difficulty waking in the a.m. | Sleep with an electric blanket |

### How many hours do you sleep in a 24-hour period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### 

### **Urinary and Genital**

|  |  |  |
| --- | --- | --- |
| Scanty or small amount of urine | Pain or burning when urinating | Sores on genitals |
| Dark urine | Flow does not stop quickly | Pain during intercourse |
| Strong smelling urine | Dribbling | Low sexual energy |
| Cloudy urine | Bed wetting | Excessive sexual energy |
| Profuse of large amount of urine | Pain in bladder area | Inability to maintain erection |
| Clear urine | Blood in urine | Inability to achieve orgasm |
| Unable to hold urine | Bladder infection | Prostate problems |
| Urgency to urinate | Kidney infection | Ejaculation during sleep |
| Frequent urination | Kidney stones | Premature ejaculation |
| Difficulty urinating | Lumps on testicles | Low sperm count |
| Decreased flow of urine | Painful testicles |  |

How often do you urinate in 24 hours? \_\_\_\_ How often do you wake to urinate at night? \_\_\_

Any other problems with your urinary system? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Pregnancy and Gynecology**

|  |  |  |
| --- | --- | --- |
| Number of pregnancies | Light flow | Uterine fibroids |
| Number of births | Light colored/pale blood | Ovarian cysts |
| Premature births | Painful periods | Breast cysts or lumps |
| Miscarriages | Endometriosis | Pelvic inflammatory disease |
| Abortions | Cramping before period starts | Current use of birth control pills |
| Difficult deliveries | Cramping after period starts | Previous use of birth control pills |
| Caesarean sections | Low backache with period | Currently have an IUD |
| Age of children | Spotting between periods | Previously had an IUD |
| Age at first menses | Missed periods | Other birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Starting date of last menses | Premenstrual irritability | Cannot maintain pregnancy |
| Duration of flow | Premenstrual emotional sensitivity | Trying to become pregnant |
| Length of cycle | Premenstrual breast tenderness | Infertility |
| Age at start of menopause | Premenstrual bloating | Pregnant |
| Age menses stopped | Premenstrual fluid retention | Nursing |
| Have not yet begun menstruating | Premenstrual headache | Nausea or morning sickness |
| Hysterectomy  Reason for: | Premenstrual constipation | Clots  dark purple  dark brown  red |
| Oophorectomy  Reason for: | Premenstrual diarrhea | Vaginal discharge  no odor  strong odor, brownish  white/curd-like  frothy & profuse  itchy  burning |
| Irregular flow | Hot flashes |  |
| Heavy flow | Abnormal pap |  |

Any other pregnancy or gynecological problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last pap test \_\_\_\_\_\_\_\_\_\_\_\_\_

# Respiratory

|  |  |  |
| --- | --- | --- |
| Chronic cough | Yellowish phlegm | Wheezing |
| Dry cough | Blood in phlegm | Frequent chest colds |
| Tight, rattling cough | Bronchitis | Asthma, worse on exhaling |
| Loose cough | Pneumonia | Asthma, more difficult to inhale |
| Thick, stick phlegm | Pain with deep breath | Asthma, more difficult to exhale |
| Thin, watery phlegm | Shortness of breath |  |
| Clear or water phlegm | Emphysema |  |

# Head, Ears, Nose, Mouth, Throat and Neurological

|  |  |  |
| --- | --- | --- |
| Frequent colds | Numbness | Decreased sense of smell |
| Sinus congestion or pain | Changes in handwriting | Dry mouth |
| Facial pain | Headache | Excessive saliva or drooling |
| Jaw tension or clicking (TMJ) | Migraine headache | Taste in mouth |
| Grinding teeth | Congestion in ears | Taste changes |
| Frequent dental cavities | Earache | Sores on tongue |
| Gum problems | Ringing in ears | Sores in mouth (canker) |
| Bleeding gums | Difficulty hearing | Sores of lips (fever blister) |
| Dentures | Motion sickness | Difficulty swallowing |
| Dizziness or loss of balance | Deafness | Lump or pit in throat |
| Convulsions | Nasal congestion | Sore throat |
| Trembles | Runny nose | Strep throat |
| Concussion | Nose bleeds | Swollen lymph nodes |
| Seizures | Sneezing | Tonsillitis |
| Faintness | Allergies |  |

# General

|  |  |  |
| --- | --- | --- |
| Head or chest cold | Jaundice | Recent weight loss |
| Flu | Armpits or groin swellings | Recent weight gain |
| Recurrent fever | Anemia | Often thirsty |
| Chills | Always fatigued | Seldom thirsty |
| Night sweats | Fatigued easily | Alcohol use |
| Perspire easily w/o exertion | Sudden drop in energy | Smoking |
| Rarely perspire | Recreational or hard drugs |  |

#### Emotional

|  |  |  |
| --- | --- | --- |
| Depression | Mood swings | Frequent crying |
| Suicidal feelings | Manic episodes | Anxiety or fear |
| Frequent anger or irritation | Sadness or grief | Indecisiveness |
| Tendency to repress emotions | Obsessiveness or compulsiveness | Difficulty handling stress |
| Lonely | Loses temper easily | Difficulty relaxing |
| Frightening dreams or thoughts | Lack of concentration or memory | Shy or sensitive |
| Sexual difficulties | Worry a lot | Desired psychiatric help |

Have you ever been emotionally, physically or sexually abused? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for emotional problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently had any unusually stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)? Describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there constant stress in your life, at work, with your family, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any other emotional problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By entering my name, this is my electronic signature for consent.