THE UNIVERSITY OF KANSAS PHYSICIANS
Integrative Medicine

New Patient Intake Form

Name_____ Preferred Name: _____
(last) (First) (middle)

Date of Birth_____ Birthplace_____ Sex M/F
(month) (day) (year)

Street Address _____
(street name and number) (city) (state) (zip)

E-mail Address _____

Home Phone _____ Cell Phone_____ Business Phone _____

Single: Y/N Married/Partner: Y/N How many times? ____ Current Spouse/Partner _____

Widow(er): Y/N Divorced: Y/N How many times? ___

Employed by _____ Occupation _____

Employer's Address _____

In Emergency Notify _____ Phone _____

Education: Years in High School _____ Years in College _____ Years Post Grad _____

Height _____ Weight: Now _____ One year ago _____ Maximum _____ When _____

Date of last physical exam ____/____/_____

Primary Care Doctor _____
Phone _____
Address _____
_____

Other Important Practitioners/Physicians
_____
_____
_____

Pharmacy Name and Phone Number _____

Reason for visit:

_____
_____

We do not submit insurance. At the time of your payment, you will get a copy of your charge sheet and a receipt that you may submit to your insurance company for reimbursement.

Signature _____ Date _____

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Referred by:

___ Physician referral (name) _____
___ Friend or family
___ Other (please list below)

Please check the color that best describes your hair.
☐ Brown ☐ Black ☐ Blonde ☐ Red ☐ White ☐ Gray ☐ Bald

Please check the color that best describes your eyes.
☐ Blue ☐ Brown ☐ Green ☐ Gray ☐ Hazel

Please check which best describes your handedness.
☐ Right ☐ Left ☐ Ambidextrous

Please check the body type that best describes yours.

☐ Ectomorph (slim, rangy body type)
☐ Endomorph (rounder, plumper body type)
☐ Mesomorph (thicker, muscular body type)

Please indicate any personal history below:

Constitutional		**Gastrointestinal**	
Good general health lately	Y/N	Loss of appetite	Y/N
Recent weight change	Y/N	Change in bowel movements	Y/N
Decreased appetite	Y/N	Nausea or vomiting	Y/N
Fever/night Sweats	Y/N	Frequent diarrhea	Y/N
Fatigue/weakness	Y/N	Painful bowel movements or constipation	Y/N
Headaches	Y/N	Rectal bleeding or blood in stool	Y/N
		Abdominal pain	Y/N
Eyes		Ulcer	Y/N
Eye disease or injury	Y/N		
Wear glasses/contact lenses	Y/N	**Genitourinary**	
Blurred or double vision	Y/N	Frequent urination	Y/N
Glaucoma/cataracts	Y/N	Burning or painful urination	Y/N
		Awaken at night to urinate	Y/N
Ears/Nose/Throat		Blood in urine	Y/N
Hearing loss or ringing	Y/N	Change in force of stream when urinating	Y/N
Earaches or drainage	Y/N	Incontinence or dribbling	Y/N
Chronic sinus problems	Y/N	Sores or discharge	Y/N
Nose bleeds	Y/N	Kidney stones	Y/N
Mouth sores	Y/N	Sexual difficulty	Y/N
Sore throat or voice change	Y/N	Male testicular pain/lumps	Y/N
Swollen glands in neck	Y/N	Female – pain with periods	Y/N
		Female – irregular periods	Y/N
Cardiovascular		Female – vaginal discharge	Y/N
Heart trouble	Y/N	Female - # of pregnancies	Y/N
Chest pain or angina pectoris	Y/N	Female - # of miscarriages	Y/N
Palpitation	Y/N	Female – date of last pap smear	Y/N
Shortness of breath with walking or lying flat	Y/N		
Swelling of feet, ankles or hands	Y/N	**Musculoskeletal**	
		Joint pain	Y/N
Respiratory		Join stiffness or swelling	Y/N
Chronic or frequent coughs	Y/N	Weakness of muscles of joints	Y/N
Spitting up blood	Y/N	Muscle pain or cramps	Y/N

Respiratory (cont.)		**Musculoskeletal (cont.)**	
Shortness of breath	Y/N	Back Pain	Y/N
Asthma or wheezing	Y/N	Difficulty walking	Y/N
Integumentary (skin, breast)		**Endocrine**	
Rash or itching	Y/N	Glandular or hormone problem	Y/N
Change in skin color	Y/N	Thyroid Disease	Y/N
Change in hair or nails	Y/N	Diabetes (insulin or non-insulin)	Y/N
Varicose veins	Y/N	Excessive thirst or urination	Y/N
Breast pain	Y/N	Heat or cold intolerance	Y/N
Breast lump	Y/N		
Breast discharge	Y/N	**Hematologic/Lymphatic**	
		Slow to heal after cuts	Y/N
Neurological		Bleeding or bruising tendency	Y/N
Frequent or recurring headaches	Y/N	Anemia	Y/N
Light headed or dizzy	Y/N	Blood clots	Y/N
Convulsions or seizures	Y/N	Blood transfusion	Y/N
Shakes	Y/N	Enlarged glands	Y/N
Paralysis	Y/N		
Stroke	Y/N	**Allergic/Immunologic**	
Head injury	Y/N	History of skin reaction or other adverse reaction to:	
		Penicillin or other antibiotics	Y/N
Psychiatric		Morphine, Demerol or other narcotics	Y/N
Memory loss or confusion	Y/N	Novocaine or other anesthetics	Y/N
Nervousness	Y/N	Aspirin or other pain remedies	Y/N
Depression	Y/N	Tetanus antitoxin or other serums	Y/N
Difficulty sleeping	Y/N	Iodine, Merthiolate or other antiseptic	Y/N

Other drug/medication allergies:

_____

_____

Known food allergies:

_____

_____

Environmental allergies:

Excessive exposure at home or work to:
Fumes?.....Yes No
Dust?.....Yes No
Solvents?.....Yes No
Air Borne Participles?.....Yes No
Others:_____

_____

Exposure History:

Use of alcohol: ☐ Never ☐ On occasion ☐ Moderately ☐ Daily
Use of tobacco: ☐ Never ☐Previously ☐Currently smoking
When started _____/# Packs per day _____/If quit, when _____
Drugs: ☐ Never ☐ On occasion ☐ Moderately ☐ Daily
Type_____/frequency_____

Please rank your most troubling symptoms by level of concern to you.

PROBLEM	ONSET	FREQUENCY	SEVERITY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

What diagnosis or explanations have been given in the past?

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When was the last time you were in really good health? _____

Do you see yourself in good health again in the future? Yes or No

Taking everything into consideration, are you: much worse / worse / the same / better / much better than 6 months ago?

How much have you spent personally on medical treatment in the past 5 years? _____

How much has your insurance company spent on your medical treatment in the past 5 years? _____

What has happened to you as a consequence of your illness? _____
_____
_____
_____
_____

What has happened to your family as a consequence of your illness? _____
_____
_____
_____
_____

What is the relationship between what is happening in your life now and what was happening about a year ago?
_____
_____
_____
_____

How will you know you are better as the result of learning new strategies at KUMC Integrative Medicine?
_____
_____
_____
_____

What are your future goals?
_____
_____
_____
_____

Operations:

	When		When
Tonsillectomy	_____	Appendectomy	_____
Hysterectomy	_____	Hernia	_____
Gall Bladder	_____	P.E. Tubes in ears	_____
1st Dental Filling	_____	1st Root Canal	_____

How many ____ What type _____ How many____ Caps _____

Other surgeries _____ _____

Illnesses:

	When		When
Chicken Pox	_____	Mononucleosis	_____
Measles	_____	German Measles	_____
Mumps	_____	Hepatitis	_____

Other_____
_____

Injuries:

	When		When
Head Injury	_____	Broken _____	_____
Neck Injury	_____	Broken _____	_____
Back Injury	_____		

Other:
_____

_____

Diagnostic Studies:

When have you had a(n):

Mammogram _____

Pap Smear _____

EKG _____

Endoscopy _____

Colonoscopy _____

Upper GI Series _____

Barium Enema _____

Bone Density _____

Chest X-ray _____

Brain _____

Abdomen _____

Spine _____

Liver Scan _____

Neck X-ray _____

Immunizations:

Pneumovax ____/____/____

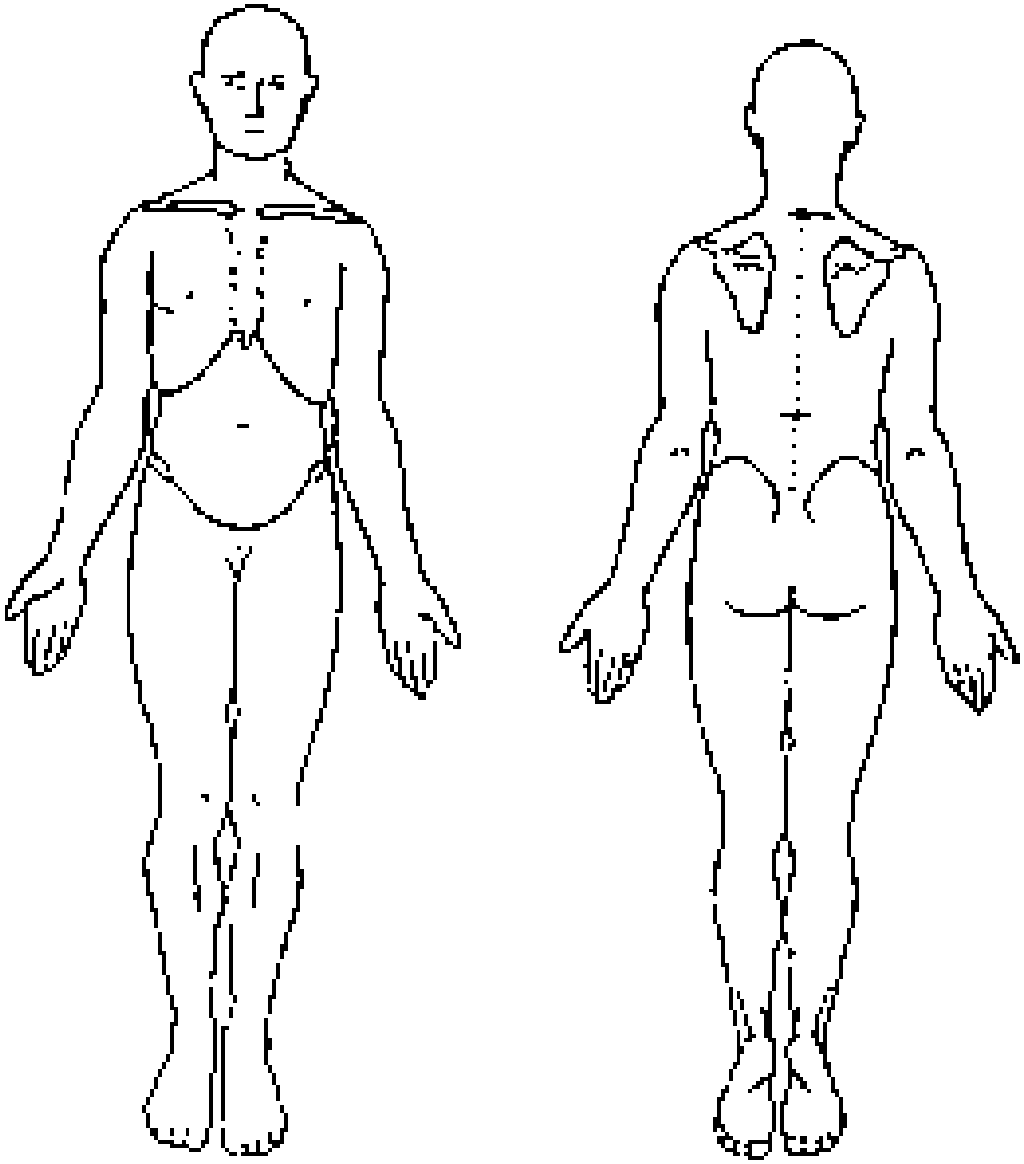
Hepatitis Vaccination ___/___/___

Flu ____/____/____

Completed Childhood Vaccines
____/____/____

Last Tetanus Booster
___/___/___

Pain Diagram



Please mark the location(s) of your pain with an "x" on the diagram above. If whole areas are painful, please shade in the painful area.

How often do you have your pain?

- ☐ Constantly (100% of the time)
- ☐ Nearly constantly (60% to 95% of the time)
- ☐ Intermittently (30% to 60% of the time)
- ☐ Occasionally (less than 30% of the time)

Medication/Supplement List

How many times and at what ages have you taken

	Infancy	Childhood	Teen	Adulthood
Antibiotics	______	______	______	______
Steroids	______	______	______	______

Include non-prescription drugs as well as vitamins, minerals, and other nutritional supplements. Indicate the mg or IUs and the form (e.g. calcium vs. calcium lactate) when possible.

Supplements / Medications	Dose	Units	Frequency	Start Date	Stop Date
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____
				___ / ___ / _____	___ / ___ / _____

Family History

Please complete the following information as it relates to your family's health history.

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brother				
Brother				
Sister				
Sister				
Spouse				
Son				
Son				
Daughter				
Daughter				

Place an "X" in the appropriate column for any illnesses that your blood relatives have experienced. Take your time filling out this questionnaire and feel free to discuss these items with your family members.

Illnesses	Father	Mother	Brothers or Sisters	Grand-Parents	Children
Alcoholism/Substance abuse					
Allergies					
Anemia					
Appendicitis					
Arthritis/Rheumatism					
Asthma					
Birth Defects					
Bleeding					
Blood Pressure – High					
Blood Pressure – Low					
Bronchitis – Chronic					
Bursitis, Sciatica, Lumbago					
Cancer					
Cholesterol – High					
Chronic Illness – Undiagnosed					
Cirrhosis					
Colon Problem					
Convulsions					
Depression					
Emphysema					
Gall Bladder Disease					
Headache					
Heart Problem					
Hepatitis					
Hernia					
Hemorrhoids					
Hypoglycemia					

Illnesses	Father	Mother	Brothers or Sisters	Grand-Parents	Children
Jaundice					
Kidney or bladder problems					
Meningitis					
Menstrual Problems					
Mental Illness					
Miscarriage or Spontaneous Abortion					
Neurologic Disorder					
Obesity					
Pleurisy					
Pneumonia					
Polio					
Prostate Problems					
Rheumatic Fever					
Skin Problems					
Stroke					
Stomach or Small Intestinal Disease					
Suicide – Attempt or Successful					
Surgeries					
Teeth/Gum Problems					
Transfusions					
Triglycerides – High					
Tuberculosis					
Ulcers					
Vaginal Problems					
Varicose Veins					
Venereal Disease					

Current Symptom Profile

Please circle the dot that best approximates how you've been feeling for the past month on each symptom listed below.

Use margins for comments.

	Health ←---------→ Disease	
1. Energetic	• • • • • • •	Fatigued
2. Ease of completing tasks	• • • • • • •	Difficulty completing tasks
3. Headache-free	• • • • • • •	Headaches
4. Migraine-free	• • • • • • •	Migraines
5. Anger-free	• • • • • • •	Angry often
6. No fluid retention	• • • • • • •	Fluid retention
7. Calm	• • • • • • •	Anxious
8. Content	• • • • • • •	Restless, cannot keep still
9. Confident	• • • • • • •	Panicky
10. Feel useful and needed	• • • • • • •	Feel useless
11. Healthy hair	• • • • • • •	Hair loss
12. Depression-free	• • • • • • •	Depressed
13. Laugh often	• • • • • • •	Crying spells
14. Happy to be alive	• • • • • • •	Feel better off dead
15. Good memory	• • • • • • •	Poor memory
16. Good concentration	• • • • • • •	Cannot concentrate
17. Easy to make decisions	• • • • • • •	Difficult to make decisions
18. Sexual function OK	• • • • • • •	Sexual dysfunction
19. Healthy nails	• • • • • • •	Nail abnormalities
20. Strong motivation	• • • • • • •	Low motivation
21. Full life	• • • • • • •	Empty life
22. BM 1 to 3 times/day	• • • • • • •	Constipation
23. Healthy bowels	• • • • • • •	Bowel spasms / diarrhea
24. Healthy weight	• • • • • • •	Overweight
25. Healthy skin	• • • • • • •	Dry skin
26. Good sleep	• • • • • • •	Insomnia
27. Daytime alertness	• • • • • • •	Daytime drowsiness
28. Feel best in A.M.	• • • • • • •	Feel best in P.M.
29. Healthy joints	• • • • • • •	Joint dysfunction
30. Allergy-free	• • • • • • •	Allergies
31. Breath freely	• • • • • • •	Wheezing
32. Adequate breath	• • • • • • •	Short of breath
33. Good muscle tone	• • • • • • •	Muscle spasms
34. Itch-free	• • • • • • •	Itchiness
35. Normal cholesterol	• • • • • • •	High cholesterol
36. Strong stomach	• • • • • • •	Gastric pains
37. Nicotine-free	• • • • • • •	Nicotine user
38. Caffeine-free	• • • • • • •	Caffeine user
39. Healthy throat	• • • • • • •	Sore throat
40. Normal sweat	• • • • • • •	Too much or too little sweat
41. Normal body odor	• • • • • • •	Offensive body odor
42. Tolerate cold well	• • • • • • •	Cold intolerant
43. Blood pressure OK	• • • • • • •	Blood pressure high
44. Resistant to colds	• • • • • • •	Over 4 colds a year
45. Normal urination	• • • • • • •	Urination difficulty
46. Regular urination	• • • • • • •	Frequent urination
47. Normal balance	• • • • • • •	Dizzy, imbalanced
48. No ringing in ears	• • • • • • •	Ringing in ears

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	Health ←----------						→ Disease
49. Heal quickly	•	•	•	•	•	•	• Heal slowly
50. Rarely bruise	•	•	•	•	•	•	• Bruise easily
51. Stable body heat	•	•	•	•	•	•	• Hot flashes/flushing
52. Warm hands/feet	•	•	•	•	•	•	• Cold hands/feet
53. Skin is clear	•	•	•	•	•	•	• Rashes, acne
54. Swallow easily	•	•	•	•	•	•	• Difficulty swallowing
55. Good skin color	•	•	•	•	•	•	• Pale, poor color
56. Alert after eating	•	•	•	•	•	•	• Drowsy after eating
57. Clear vision	•	•	•	•	•	•	• Poor vision
58. See well at night	•	•	•	•	•	•	• Poor night vision
59. No hives	•	•	•	•	•	•	• Hives
60. Fresh breath	•	•	•	•	•	•	• Bad breath
61. Regular heartbeat	•	•	•	•	•	•	• Irregularities
62. Dream recall	•	•	•	•	•	•	• No dream recall
63. Good dreams	•	•	•	•	•	•	• Nightmares
64. Healthy mouth	•	•	•	•	•	•	• Mouth/lip sores
65. Digest well	•	•	•	•	•	•	• Indigestion, bloating
66. Normal sensations	•	•	•	•	•	•	• Numbness or burning
67. Sinuses clear	•	•	•	•	•	•	• Sinus congestion
68. Healthy tongue	•	•	•	•	•	•	• Sore tongue
69. Hands are steady	•	•	•	•	•	•	• Skakiness, tremor
70. Steady arms and legs	•	•	•	•	•	•	• Arms and legs shake & tremble
71. Feel strong	•	•	•	•	•	•	• Weakness
72. Normal nails	•	•	•	•	•	•	• White spots on nails
73. Healthy jaws	•	•	•	•	•	•	• Jaw pain
74. Healthy back	•	•	•	•	•	•	• Back pain
75. Normal thirst	•	•	•	•	•	•	• Excessive thirst
76. Healthy gums	•	•	•	•	•	•	• Bleeding, sore gums
77. Normal teeth	•	•	•	•	•	•	• Loose teeth
78. Eyes comfortable	•	•	•	•	•	•	• Eyes dry, irritated
79. Normal taste/smell	•	•	•	•	•	•	• Diminished taste/smell
80. Legs relaxed	•	•	•	•	•	•	• Restless legs
81. Bright lights OK	•	•	•	•	•	•	• Bright lights bother
82. Normal voice	•	•	•	•	•	•	• Hoarseness
83. Restful sleep	•	•	•	•	•	•	• Wake up tired
84. Ache free muscles	•	•	•	•	•	•	• Muscles ache
85. Normal appetite	•	•	•	•	•	•	• Loss of appetite
86. No craving for sugar	•	•	•	•	•	•	• Often crave sugar
87. No craving for salt	•	•	•	•	•	•	• Often crave salt
88. Normal appetite for bread	•	•	•	•	•	•	• Often crave bread
89. No craving for chocolate	•	•	•	•	•	•	• Often crave chocolate
90. No craving for coffee	•	•	•	•	•	•	• Often crave coffee
91. No craving for alcohol	•	•	•	•	•	•	• Often crave alcohol
For Females Only							
92. Premenstrual OK	•	•	•	•	•	•	• Premenstrual bad
93. Normal menstruation	•	•	•	•	•	•	• Irregular/heavy flow
94. Normal breasts	•	•	•	•	•	•	• Breast lumps, pain
95. Vaginal infection free	•	•	•	•	•	•	• Vaginal infections
For Males Only							
96. Normal erections	•	•	•	•	•	•	• Erection problems
97. Prostate healthy	•	•	•	•	•	•	• Prostate problems
98. No testicular problems	•	•	•	•	•	•	• Testicular problems

Please add any important symptoms you have, which have not been noted above. You may write them in the format used above if you wish.

_____
_____
_____
_____
_____
_____
_____

Current Health Behaviors Profile

Please circle the dot that best approximates how you've been doing on each of the following health producing behaviors.

Use margins for comments.

	Health ←----------→ Disease	
1. Drink 8 glasses of water per day	• • • • • • •	• Drink very little water per day
2. Rarely salt food	• • • • • • •	• Salt food a lot
3. Read food labels	• • • • • • •	• Never read food labels
4. Chew food thoroughly	• • • • • • •	• Chew food very little
5. Use glass, enamel, or stainless cookware	• • • • • • •	• Use aluminum cookware
6. Regular bedtime	• • • • • • •	• Very irregular bedtime
7. Sleep 7 to 8 hours	• • • • • • •	• Sleep a lot or little
8. Regular time to rise	• • • • • • •	• Irregular rising time
9. Two or less alcohol drinks per day	• • • • • • •	• Alcohol consumption detrimental
10. Never drive under influence	• • • • • • •	• Drive after drinking alcohol
11. Choose whole foods	• • • • • • •	• Eat mostly refined foods daily
12. Choose wide variety of foods	• • • • • • •	• Eat same small group of foods
13. Drink only water or fruit juice	• • • • • • •	• Drink many sweetened or caffeinated drinks
14. Never use refined sugar	• • • • • • •	• Often add sugar
15. Walk regularly	• • • • • • •	• Don't walk regularly
16. Climb stairs when possible	• • • • • • •	• Stay away from stairs when possible
17. Breathe deeply and fully	• • • • • • •	• Breathe shallowly
18. Daily stretching exercises	• • • • • • •	• Seldom do stretching exercises
19. Work on good posture	• • • • • • •	• Seldom intentionally change posture
20. Daily exposure to sunlight	• • • • • • •	• Seldom outdoors
21. Satisfying job	• • • • • • •	• Unsatisfying job
22. Satisfying marriage	• • • • • • •	• Unsatisfying marriage
23. Cultivate good friendships	• • • • • • •	• No good friends
24. Eat 2 raw vegetable salads per day	• • • • • • •	• Eat no raw vegetables
25. Eat meals in harmonious atmosphere	• • • • • • •	• Much stress during meals
26. Meditate or practice relaxation daily	• • • • • • •	• Never stop to relax or meditate
27. Rarely watch TV	• • • • • • •	• Spend hours every day watching TV
28. Cultivate personal hobbies or recreation	• • • • • • •	• Have no hobby or regular
29. Financially stable	• • • • • • •	• Financially unstable
30. Laugh several times a day	• • • • • • •	• Seldom laugh
31. Compliment others regularly	• • • • • • •	• Almost never compliment others
32. Listen to body signals	• • • • • • •	• Try to ignore body signals
33. Stop eating when satisfied	• • • • • • •	• Consistently overeat
34. Read health-related articles daily	• • • • • • •	• Seldom read health related literature
35. Ask doctor questions when curious	• • • • • • •	• Afraid to ask doctor questions when
36. Take time to evaluate and plan ahead	• • • • • • •	• Rushed and seldom take time to plan ahead

List important health behaviors or other information that was not included above that you feel would be beneficial for us to know:

_____

_____

_____

_____

_____

_____

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Diagnosis Profile

1. If you have ever been diagnosed with any of the items listed below, please indicate the approximate date the diagnosis was made.
2. If you are currently still having problems resulting from the disease diagnosed, please indicate how severe those difficulties are by circling the dot which best represents that severity.

Understanding the seven dot scale:

No problem	(•)	•	•	•	•	•	•
Moderate problem	•	•	(•)	•	•	•	•
Moderately severe problem	•	•	•	•	(•)	•	•
Severe Problem	•	•	•	•	•	•	(•)

Year of Onset	**Current Severity**						
	None						**Severe**
_____ Achlorhydria (low or absent stomach acid)	•	•	•	•	•	•	•
_____ Acne	•	•	•	•	•	•	•
_____ Alcoholism	•	•	•	•	•	•	•
_____ Alcoholism in Remission	•	•	•	•	•	•	•
_____ Allergy, Unknown Origin	•	•	•	•	•	•	•
_____ Alzheimer's	•	•	•	•	•	•	•
_____ Amebiasis (microscopic parasite)	•	•	•	•	•	•	•
_____ Anemia, Iron Deficiency	•	•	•	•	•	•	•
_____ Anemia, General	•	•	•	•	•	•	•
_____ Angina (chest pain)	•	•	•	•	•	•	•
_____ Anxiety Disorder	•	•	•	•	•	•	•
_____ Arrhythmia (irregular heartbeat)	•	•	•	•	•	•	•
_____ Arteriosclerosis (stiffening of arteries)	•	•	•	•	•	•	•
_____ Arthritis	•	•	•	•	•	•	•
_____ Arthritis, Allergic	•	•	•	•	•	•	•
_____ Arthritis, Psoriatic	•	•	•	•	•	•	•
_____ Arthritis, Rheumatoid	•	•	•	•	•	•	•
_____ Asthma	•	•	•	•	•	•	•
_____ Back Pain	•	•	•	•	•	•	•
_____ Blood Pressure-High	•	•	•	•	•	•	•
_____ Blood Pressure-Low	•	•	•	•	•	•	•
_____ Bronchitis	•	•	•	•	•	•	•
_____ Cancer, Breast	•	•	•	•	•	•	•
_____ Cancer, Bladder	•	•	•	•	•	•	•
_____ Cancer, Prostate	•	•	•	•	•	•	•
_____ Cancer, Cervix/Uterus	•	•	•	•	•	•	•
_____ Cancer, Lung	•	•	•	•	•	•	•
_____ Cancer, Skin	•	•	•	•	•	•	•
_____ Cancer, Other _____	•	•	•	•	•	•	•
_____ Carpal Tunnel Syndrome	•	•	•	•	•	•	•
_____ Chronic Fatigue Syndrome	•	•	•	•	•	•	•
_____ Cirrhosis	•	•	•	•	•	•	•
_____ Colitis	•	•	•	•	•	•	•
_____ Collagen Disease	•	•	•	•	•	•	•
_____ Conjunctivitis (Pink Eye)	•	•	•	•	•	•	•
_____ Cystitis (bladder inflammation)	•	•	•	•	•	•	•
_____ Depression	•	•	•	•	•	•	•
_____ Diabetes	•	•	•	•	•	•	•

Year of Onset	Current Severity						
	None						Severe
_____ Eczema	•	•	•	•	•	•	•
_____ Edema (swelling)	•	•	•	•	•	•	•
_____ Fluid Retention	•	•	•	•	•	•	•
_____ Emphysema	•	•	•	•	•	•	•
_____ Endometriosis	•	•	•	•	•	•	•
_____ Epilepsy	•	•	•	•	•	•	•
_____ Farsighted	•	•	•	•	•	•	•
_____ Food Allergy	•	•	•	•	•	•	•
_____ Gall Bladder Disease	•	•	•	•	•	•	•
_____ Headache, Migraine	•	•	•	•	•	•	•
_____ Headache, Tension	•	•	•	•	•	•	•
_____ Heart Disease	•	•	•	•	•	•	•
_____ Heavy Metal Poisoning	•	•	•	•	•	•	•
_____ Hepatitis	•	•	•	•	•	•	•
_____ Hypercholesterolemia (high blood cholesterol)	•	•	•	•	•	•	•
_____ Hyperthyroid	•	•	•	•	•	•	•
_____ Hypoglycemia (low blood sugar)	•	•	•	•	•	•	•
_____ Intestinal Candidiasis (yeast)	•	•	•	•	•	•	•
_____ Intestinal Malabsorption	•	•	•	•	•	•	•
_____ Intestinal Parasites	•	•	•	•	•	•	•
_____ Irritable Bowel Syndrome	•	•	•	•	•	•	•
_____ Lead Poisoning	•	•	•	•	•	•	•
_____ Lumbar Sprain	•	•	•	•	•	•	•
_____ Lupus	•	•	•	•	•	•	•
_____ Manic Depressive	•	•	•	•	•	•	•
_____ Mitral Valve Prolapse	•	•	•	•	•	•	•
_____ Multiple Sclerosis	•	•	•	•	•	•	•
_____ Myositis (inflammation of skeletal muscles)	•	•	•	•	•	•	•
_____ Nearsightedness	•	•	•	•	•	•	•
_____ Nervousness	•	•	•	•	•	•	•
_____ Obesity	•	•	•	•	•	•	•
_____ Osteoarthritis	•	•	•	•	•	•	•
_____ Panic Attacks	•	•	•	•	•	•	•
_____ Parasitic Disease NEC	•	•	•	•	•	•	•
_____ Phlebitis (inflammation of a vein)	•	•	•	•	•	•	•
_____ Pneumonia	•	•	•	•	•	•	•
_____ Premenstrual Syndrome	•	•	•	•	•	•	•
_____ Prostatitis (inflammation of the prosate)	•	•	•	•	•	•	•
_____ Rash, Unspecified	•	•	•	•	•	•	•
_____ Scurvy	•	•	•	•	•	•	•
_____ Seizure Disorder w/convulsions	•	•	•	•	•	•	•
_____ Senile Dementia	•	•	•	•	•	•	•
_____ Sinusitis	•	•	•	•	•	•	•
_____ Sjogren's Disease	•	•	•	•	•	•	•
_____ Tachycardia (fast heart rate)	•	•	•	•	•	•	•
_____ Tenosynovitis(inflammation of tendon sheath)	•	•	•	•	•	•	•
_____ Thyroid Disease Unspecified	•	•	•	•	•	•	•
_____ Tinnitus (ringing in the ears)	•	•	•	•	•	•	•
_____ Tonsillitis	•	•	•	•	•	•	•
_____ Ulcer, Bleeding, Chronic	•	•	•	•	•	•	•
_____ Urinary Tract Infection	•	•	•	•	•	•	•
_____ Vasomotor Rhinitis (Constant stuffy or runny nose)	•	•	•	•	•	•	•
_____ Vertigo	•	•	•	•	•	•	•

Year of Onset	Current Severity						
	None						Severe
_____ Viral Infection, Unspecified	•	•	•	•	•	•	•
_____ Vitiligo (depigmentation of skin)	•	•	•	•	•	•	•
_____ Weakness, General	•	•	•	•	•	•	•
_____ Weight Gain, Abnormal	•	•	•	•	•	•	•
_____ Wheezing Respiration	•	•	•	•	•	•	•

Other Diagnosis (write in): _____
_____
_____
_____

Reviewed By: _____ Date: _____