MAUI REGENERATIVE MEDICINE

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## Patient History Information

| | | | |
|---|---|---|---|
| Name | | Date | |
| Address | | State/Zipcode | |
| Phone Home | Cell | SSN# | |
| Age | Date of Birth | Sex | M F |
| Occupation | | Employer | |
| Marital Status: S M W D | No. of Children: | Spouse Name | |
| Emergency Contact Name and Phone | | | |
| Email | | | |
| How did you find out about our office? | | | |
| How do you prefer we contact you: | | | |
| What is the reason for this visit? | | | |

Is this condition due to: Auto accident Work Injury Other accident Illness Other

Are symptoms: Improving Getting worse About the same Intermittent

Date symptoms appeared: Have you ever had these symptoms before? Yes No

Have you seen any of the following doctors for this? MD Naturopathic Dr

Chiropractor Acupuncturist Other:

Therapy Received: Dates treated:

Diagnosis:

Reason for termination of treatment:

Medications Prescribed:

Doctors Name:

I understand that a 24 hour advance notification is required for scheduling or cancelling of appointments to avoid a charge. I understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature: Date

## Health History *(continued)*

**Typical example of:**
**Breakfast** _____
_____
**Lunch** _____
_____
**Supper** _____
_____

Have you been observing any special dietary restrictions? _____
_____
_____

Exercise habits
*(list kind of exercise, frequency - times per week & duration - minutes per day):*
_____
_____
_____
_____
How many years have you had a regular exercise program? _____

**Bowel habits:**
☐ regular ☐ irregular
*(please mark "f"=frequently, "oc"=occasionally)*
Have you experienced:
☐ constipation _____
☐ diarrhea _____
☐ mucous on stool _____
☐ blood on stool _____
☐ undigested food _____

**Energy level:**
☐ good
☐ drops in the afternoon
☐ low upon waking
☐ drops unpredictably
☐ low after eating

**Sleep habits:**
☐ sleep well, wake rested
☐ wake _____ times in the night at _____am/pm
☐ difficulty falling asleep
☐ dreams
☐ nightmares
☐ wake tired

**Urination:** _____times/day wake _____times/night

**Appetite:**
☐ good ☐ poor
Food cravings for _____
Preferred flavor (circle): *salty, spicy, sour, sweet, bitter*
Diet:
☐ 3 meals/day ☐ small fequent meals
☐ Eat at restaurant _____ times/week
Digestion:
☐ Frequent bloating ☐ belching
☐ nausea ☐ Stomach rumbles
Intolerant of:
☐ fats & oils ☐ raw vegetables
☐ sweets ☐ proteins

**Pain:**
☐ head ☐ neck ☐ shoulders
☐ mid back ☐ low back ☐ extremities
☐ chest ☐ stomach ☐ abdomen
☐ groin ☐ genitalia
Was this a result of an accident? _____ Explain: _____
_____
_____
Onset of symptoms: _____
Relieved by:
☐ hot ☐ cold ☐ pressure ☐ motion ☐ lying still
describe nature of pain _____
Exact location: _____
Type:
☐ sharp ☐dull ☐ throbbing ☐ constant
☐ tearing ☐ aching ☐ other _____

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*(Give approximate age when illness occurred.)*

- ☐ chicken pox _____
- ☐ mumps _____
- ☐ orthopaedic problems _____
- ☐ measles _____
- ☐ herpes simplex _____
- ☐ mononucleosis _____
- ☐ parasites _____
- ☐ skin conditions _____
- ☐ known allergies:
  - ☐ foods _____
  - ☐ airborne _____
  - ☐ drugs _____
  - ☐ other _____
- ☐ asthma _____
- ☐ kidney disorders _____
- ☐ previous medications _____

Any unfavorable reaction? ☐ yes ☐ no
describe: _____
Any other childhood illness or injury?
*(dates & description)* _____

History of surgeries: _____

**Recent health history:**
*(mark date of onset and a brief description)*

- ☐ anemia _____
- ☐ arthritis/rheumatism _____
- ☐ bronchitis _____
- ☐ cancer _____
- ☐ chronic fatigue _____
- ☐ constipation _____
- ☐ diabetes _____
- ☐ digestive problems _____
- ☐ emotional instability _____
- ☐ headaches _____
- ☐ heart palpitations _____
- ☐ hepatitis/liver disease _____
- ☐ high blood pressure _____
- ☐ hypoglycemia (low blood sugar) _____
- ☐ long term flu _____
- ☐ menstrual problems _____
- ☐ multiple allergies _____
- ☐ shortness of breath _____
- ☐ spinal pain _____

Do you have a family history of any of the above? _____

Illness not mentioned? _____

If you've has a recurrance of a childhood or chronic illness, please give date of recurrance and brief description: _____

**Give approximate frequency of use of the following:**

- ☐ coffee _____ cups/day
- ☐ cigarettes _____ pks/day
- ☐ marijuana _____ times/week
- ☐ alcohol _____ times/week
- ☐ recreational drugs _____ times/week

**Supplements:**

- ☐ vitamins: _____ ____ times/day
  _____ ____ times/day
- ☐ enzymes: _____ ____ times/day
- ☐ minerals: _____ ____ times/day
- ☐ herbal treatments: _____ times/day
- ☐ Current prescription/ non-prescription medications: *(include doosage and duration of adminstration)* _____

- ☐ History of long-term antibiotic use: *(list type, date, and duration)* _____

- ☐ Urinary Tract Infections: *(list date and treatment)* _____

- ☐ History of travelers diarrehea or intestinal parasites: *(type of parasite, diagnosed by, symptoms & treatment)* _____

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