

Lozier Natural Health Center

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Today's Date: _____ Age _____ Sex _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____/____/____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Email Address _____
Your Occupation _____ Your Employer: _____
Social Security #: _____
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone :(____) _____
Referred to this Office by: _____

Have you been treated by a physician for any health condition in the last year? Yes No
If yes by whom _____
Describe Condition _____ Date of Last Physical Exam _____

Surgical History:
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate pain (1-10, 0-no pain to 10 worst pain)

1. _____ # _____
2. _____ # _____
3. _____ # _____
4. _____ # _____

Have you received Chiropractic care before? YES NO
Are you currently receiving chiropractic care? YES NO

What medications are you currently taking?

What nutritional supplements are you currently taking?

Are you pregnant? Yes No Date of last menstrual period _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

Lozier Natural Health Center

What do you know about our approach?

What *three* expectations do you have from *this* visit?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 1 2 3 4 5 6 7 8 9 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

Patient Name _____ Date _____

For your 1st visit-checkmark any symptom you have experienced in the last month. **For Re-exams**-checkmark symptoms you are currently experiencing.

<p>HEADACHES</p> <p>___ Base of Skull (back)</p> <p>___ Side of head (Temples)</p> <p>___ Frontal (above eyes)</p> <p>___ Top of head</p> <p>___ Entire Head</p> <p>___ Migraines</p> <p>___ TMJ</p> <p>___ Cluster</p> <p>___ Other _____</p>	<p>CHEST</p> <p>___ Tension</p> <p>___ Tight</p> <p>___ Pressure</p> <p>___ Heaviness</p> <p>___ Anxiety</p> <p>___ Congestion</p> <p>___ Chest Pain</p> <p>___ Sternal Pain</p> <p>___ Sharp Heart Pain</p> <p>___ Palpitations-Heart Skip/Flutter</p> <p>___ Mitral Valve Prolapse</p> <p>___ Tachycardia/Heart Racing</p> <p>___ Bradycardia/Heart Slowing down</p> <p>___ Murmur</p> <p>___ Arm Pain</p> <p>___ Other _____</p>	<p>For Men Only: PROSTATE</p> <p>___ History</p> <p>___ Current</p> <p>___ Burn</p> <p>___ Achyness</p> <p>___ Pain</p> <p>___ Restriction</p> <p>___ Dribbling</p> <p>___ Emission</p> <p>___ Swelling</p> <p>___ Other _____</p>	<p>CRAMPS/ ACHES/ RESTLESS</p> <p>___ Cramps (legs/feet/arms/hands)</p> <p>___ Aches (legs/feet/arms/hands)</p> <p>___ Restless (legs/feet/arms/hands)</p>	<p>ENERGY</p> <p>___ Low</p> <p>___ Variable</p> <p>___ Normal</p> <p>___ High</p> <p>___ Slow to start in the morning</p> <p>___ Energy Crash _____ am/pm</p> <p>___ Low Energy after meals</p> <p>___ Other _____</p>		
<p>EARS</p> <p>___ Noise (Ring/Hiss/Pound)</p> <p>___ Plugged</p> <p>___ Popping</p> <p>___ Ear Ache</p> <p>___ Ear Infections</p> <p>___ Draining</p> <p>___ Itchy</p> <p>___ Hearing Loss</p> <p>___ Dizziness/ Vertigo</p> <p>___ Excessive Ear Wax</p> <p>___ Other _____</p>	<p>SHORTNESS OF BREATH</p> <p>___ Constant</p> <p>___ Upon Exertion</p> <p>___ Asthma</p> <p>___ Wheezing</p> <p>___ Air Hunger/ Frequent Sighs</p> <p>___ Yawning</p> <p>___ Emphysema</p> <p>___ Other _____</p>	<p>VAGINA (women only)</p> <p>___ Burn</p> <p>___ Itch</p> <p>___ Dry</p> <p>___ Pain</p> <p>___ Pain with intercourse</p> <p>___ Blood</p> <p>___ Discharge</p> <p>___ - Clear</p> <p>___ - White</p> <p>___ - Yellow</p> <p>___ - Green</p> <p>___ - Brown</p> <p>___ - Odor</p> <p>___ Other _____</p>	<p>SKIN/ HAIR/ NAILS</p> <p>___ Skin Rash</p> <p>___ Acne</p> <p>___ Dry Skin</p> <p>___ Itchy Skin</p> <p>___ Fungus</p> <p>___ Patches skin look different</p> <p>___ Cellulite</p> <p>___ Nails (weak/ spots/ lines)</p> <p>___ Hair loss</p> <p>___ Limp Hair</p> <p>___ Cherry Hemangiomas</p> <p>___ Slow Healing</p> <p>___ Bruise Easily</p> <p>___ Other _____</p>	<p>EXERCISE</p> <p>___ Cardiovascular _____ times/ week</p> <p>___ Weight Train _____ times/per week</p>		
<p>EYES</p> <p>___ Burn</p> <p>___ Tear</p> <p>___ Ache</p> <p>___ Red</p> <p>___ Dry</p> <p>___ Eye Film</p> <p>___ Crust in morning</p> <p>___ Itchy Eyes</p> <p>___ Bouts of Blurriness</p> <p>___ Floaters</p> <p>___ Spots</p> <p>___ Tired</p> <p>___ Puffy</p> <p>___ Styte</p> <p>___ Twitching around eyes</p> <p>___ Dark Circles</p> <p>___ Light Bothers Eyes</p> <p>___ Nearsighted</p> <p>___ Farsighted</p> <p>___ Other _____</p>	<p>STOMACH</p> <p>___ Heartburn</p> <p>___ Indigestion</p> <p>___ Stomach Aches</p> <p>___ Stomach Cramps</p> <p>___ Nausea/ Queasy</p> <p>___ Bloat after Eat</p> <p>___ Gas/ Flatulence</p> <p>___ Belching</p> <p>___ Ulcer</p> <p>___ Hiatal Hernia</p> <p>___ Other _____</p>	<p>MENSES (women only)</p> <p>___ Last Menstrual Period _____</p> <p>___ Length of Menses _____</p> <p>___ Regular</p> <p>___ Irregular</p> <p>___ Early (less than 28 days)</p> <p>___ Late (more than 28 days)</p> <p>___ Skip</p> <p>___ Birth Control Pill</p> <p>___ Flow (heavy/ moderate/ light)</p> <p>___ Cramps (mild/ mod/ severe)</p> <p>___ Low Abdominal Puffiness</p> <p>___ Fluid Retention Face</p> <p>___ Fluid Retention Hands</p> <p>___ Fluid Retention Feet</p> <p>___ Fluid Retention Body</p> <p>___ Breast Tender around cycle</p> <p>___ Acne (pre/mid/post)</p> <p>___ Clotting</p> <p>___ Spotting</p> <p>___ PMS</p> <p>___ Mood Swings</p> <p>___ Irritable</p> <p>___ Depression</p> <p>___ Tired during period</p> <p>___ Pain during Ovulation</p> <p>___ Cysts/PCOS</p> <p>___ Discharge with Ovulation</p> <p>___ Regular Ovulation</p> <p>___ Irregular Ovulation</p> <p>___ Fibroids</p> <p>___ Facial Hair</p> <p>___ Hair growing up towards belly button</p> <p>___ Dark Nipple Hair</p> <p>___ Other _____</p>	<p>URINATION</p> <p>___ _____ times per day-frequency</p> <p>___ Urinate at night _____ per night</p> <p>___ Frequency</p> <p>___ Urgency</p> <p>___ Burning</p> <p>___ Pain</p> <p>___ Odor</p> <p>___ Spasm</p> <p>___ Leakage</p> <p>___ Urinary Tract Infection</p> <p>___ Kidney Troubles</p> <p>___ Other _____</p>	<p>MEMORY</p> <p>___ Short Term Loss</p> <p>___ Long Term Loss</p> <p>___ Forget Names</p> <p>___ Forget Numbers</p> <p>___ Forget Words</p> <p>___ Forget Actions</p> <p>___ Difficulty Concentrating</p> <p>___ Other _____</p>		
<p>SINUS</p> <p>___ Dry</p> <p>___ Drain</p> <p>___ Stuffy/ plugged up</p> <p>___ Post nasal drip...circle color: ___ white/yellow/green/gray ___ brown/blood/blood/clear</p> <p>___ Excessive Sneezing</p> <p>___ Loss of Smell</p> <p>___ Loss of Taste</p> <p>___ Thirsty</p> <p>___ Not Thirsty</p> <p>___ Unquenchable thirst</p> <p>___ Other _____</p>	<p>BOWELS</p> <p>___ Bowel Movements _____ Per day</p> <p>___ Regular</p> <p>___ Incomplete</p> <p>___ Skip days _____ per (week/month)</p> <p>___ Sluggish bowels every _____ days</p> <p>___ Cramps in Abdomen</p> <p>___ Taking Laxatives</p> <p>___ Using Suppositories</p> <p>___ Enemas</p> <p>___ Colonics</p> <p>___ Take Herbal Laxatives/Supplements</p> <p>___ Bulky</p> <p>___ Pain with Bowel Movements</p> <p>___ Irritable Bowel Syndrome</p> <p>___ Chrons</p> <p>___ Colitis</p> <p>___ Other _____</p>	<p>BREASTS (women only)</p> <p>___ Breast Feeding</p> <p>___ Fibrosis</p> <p>___ Lump</p> <p>___ Discharge</p> <p>___ Prosthesis</p> <p>___ Augmentation Surgery</p> <p>___ Reduction Surgery</p> <p>___ Pathology</p> <p>___ Breast Tender constant</p> <p>___ Other _____</p>	<p>SLEEP</p> <p>___ Quality (poor/fair/good/great)</p> <p>___ _____ Hours in bed</p> <p>___ _____ Hours asleep</p> <p>___ Difficulty falling asleep</p> <p>___ Difficulty staying asleep</p> <p>___ Interrupted _____ per night</p> <p>___ Crave Sleep during day</p> <p>___ Awaken Suddenly (Jolt)</p> <p>___ Don't Remember Dreams</p> <p>___ Nightmares</p> <p>___ Night sweats</p> <p>___ Restlessness</p> <p>___ Sleep Apnea</p> <p>___ Other _____</p>	<p>LIBIDO/ SEXUALITY</p> <p>___ Flat</p> <p>___ Low</p> <p>___ Normal</p> <p>___ Erectile Dysfunction (men)</p> <p>___ Orgasm Quality (poor/ good/ great)</p> <p>___ Other _____</p>		
<p>MOUTH/ THROAT/ IMMUNE</p> <p>___ Sore Throat</p> <p>___ Hoarseness</p> <p>___ Cough (dry/productive)</p> <p>___ Allergies</p> <p>___ Upper Respiratory Infection</p> <p>___ Teeth Health Problems</p> <p>___ Fever</p> <p>___ Chills</p> <p>___ Bad Breath</p> <p>___ Canker Sores</p> <p>___ Blisters</p> <p>___ Frequent Colds/ Flu</p> <p>___ Neck Stiffness</p> <p>___ Shoulder Tension</p> <p>___ Cracks at lip corners/ Chielosis</p> <p>___ Dry Mouth</p> <p>___ Cold sweaty hands & feet</p> <p>___ Bleeding gums</p> <p>___ Receding gums</p> <p>___ Teeth Health Problems</p>	<p>FECAL CONSISTENCY</p> <p>___ Color feces light or dark _____</p> <p>___ Soft/Unformed</p> <p>___ Ribbon-like</p> <p>___ Mucous</p> <p>___ Normal/ Banana Shaped</p> <p>___ Hard</p> <p>___ Pebbles</p> <p>___ Dry</p> <p>___ Painful</p> <p>___ Diarrhea</p> <p>___ Constipation</p> <p>___ Broken</p> <p>___ Other _____</p>	<p>EMOTIONS</p> <p>___ Stressed</p> <p>___ Sad</p> <p>___ Grief</p> <p>___ Depression</p> <p>___ Moodiness</p> <p>___ Irritable</p> <p>___ Worrisome</p> <p>___ Angry</p> <p>___ Nervous</p> <p>___ Frustrated</p> <p>___ Anxiety</p> <p>___ Panic</p> <p>___ Cry</p> <p>___ Fear</p> <p>___ Shame</p>	<p>APPETITE/ DIET</p> <p>___ Low Appetite</p> <p>___ Normal Appetite</p> <p>___ High Appetite</p> <p>___ Starch (pasta/bread/potatoes/rice)</p> <p>___ Sweets</p> <p>___ Chocolate</p> <p>___ Coffee _____ cups/ day</p> <p>___ Caffeinated Tea _____ cups/day</p> <p>___ Beer _____ per week</p> <p>___ Wine _____ per week</p> <p>___ Juice _____ per week</p> <p>___ Soda _____ per week</p> <p>___ Artificial Sweeteners</p>	<p>PAIN/ STIFFNESS/ SWELLING NUMBNESS/ TINGLING</p> <p>___ Facial</p> <p>___ Neck</p> <p>___ Trapezius</p> <p>___ Upper Back</p> <p>___ Shoulders</p> <p>___ Arms</p> <p>___ Elbows</p> <p>___ Wrist</p> <p>___ Hand</p> <p>___ Mid Back</p> <p>___ Low Back</p> <p>___ Sacral Iliac</p> <p>___ Hips</p> <p>___ Buttocks</p> <p>___ Legs</p> <p>___ Sciatica</p> <p>___ Knees</p> <p>___ Ankles</p> <p>___ Feet</p>		
					<p>For Doctor's Use</p> <p>___ Frenular Cyst</p> <p>___ Cracks in Tongue</p> <p>___ Allergy Patches Tongue</p> <p>___ Geographic Tongue</p> <p>___ Red Spots Tongue</p> <p>___ Swollen Tongue</p> <p>___ Color Tongue _____</p> <p>___ Dark Veins Tongue</p> <p>___ Coated Tongue (mild/mod/severe)</p> <p>___ Ear Creases (R/ L) mild/mod/severe</p> <p>___ Weight _____ (+/- lbs) overall (+/-) _____</p> <p>___ Height _____</p> <p>___ Pulse _____ BP: (____/____)</p> <p>___ saliva pH _____ Urine pH _____</p> <p>___ Allergies _____</p> <p>___ Current Meds: _____</p>	
					<p>List Your Primary Concerns in order of importance to you:</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p>4) _____</p>	
					<p>HEMORRHOIDS</p> <p>___ History</p> <p>___ Current</p> <p>___ Swollen</p> <p>___ Burn</p> <p>___ Blood</p> <p>___ Distended</p>	<p>MENOPAUSE (women only)</p> <p>___ Natural</p> <p>___ Surgical (partial/complete)</p> <p>___ Hormones</p> <p>___ Patch</p>

YOUTH HEALTH HISTORY QUESTIONNAIRE

Name _____ Today's date: _____

Age: _____ Birth Date: _____ Weight: _____ Height: _____

This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering these questions!

1. What is the reason for this visit?

2. Please list any known health conditions that your child has been diagnosed with:

3. List any **medications** your child is currently taking, or has taken in the past.

4. Please indicate any history of **antibiotic** use, listing when, what, and for what purpose.

5. Are there any known drug allergies?

6. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

7. Do you suspect your child to use recreational drugs? If so, what:

8. List any hospital procedures/surgeries that your child has had:

LIFESTYLE INDICATORS (please fill in or circle the appropriate answer)

1. Does your child consume any of the following?

Soda	none	< 2 cans / day	> 2 cans / day	
Sweets / Carbs	none	< twice / day	> twice / day	
White Flour	none	< twice / day	> twice / day	
Milk/Dairy Products	none	< twice / day	> twice / day	
Juice	none	< twice / day	> twice / day	
Meat/Fish	none	rarely	< once a week	every day

2. How much water does your child drink each day? _____

3. Are there smokers in the child's home? Yes No

4. Does your child get consistent physical activity? Yes No

5. Please list any regular exercise or sports that your child participates in:

History (please fill in or circle the appropriate answer)

1. Did your child have colic as an infant? Yes No

2. How was your child fed as an infant? Breast Bottle

What brand / kind of formula? _____

3. Has your child had any respiratory infections? Yes No

How often? _____

4. Does your child ever complain of back or neck pain? Yes No

Please explain: _____

5. Does your child ever complain of arm or leg pain? Yes No

Please explain: _____

6. Does your child ever complain of headaches? Yes No

How often? _____

7. Has your child had ear infections? Yes No

Age of the first occurrence and frequency: _____

8. Do they typically occur in the same ear? Yes No Which ear? Right Left Both

9. Please list any illnesses that your child has had and approximate dates of occurrence:

10. Has your child been vaccinated? Yes No Recently? Yes No

11. Please describe any reactions that your child has had to past or recent vaccinations:

12. Please list any other concerns you have regarding your child's health:

HISTORY

PLEASE CIRCLE THE NUMBER TO INDICATE CURRENT SYMPTOMS
PLEASE PLACE A (X) NEXT TO ANY ON GOING OR PAST PROBLEMS

GENERAL

1. FEVER
2. CHILLS
3. NIGHTS SWEATS
4. LOSS OF SLEEP
5. FATIGUE
6. NERVOUSNESS
7. WEIGHT LOSS OR GAIN
8. ALLERGIES
9. BLEEDING PROBLEMS
10. ANEMIA
11. DIABETES
12. CANCER
13. THYROID PROBLEMS
14. ALCOHOLISM
15. DRUG ABUSE

EAR, EYE, NOSE, THROAT

16. POOR VISION
17. PAIN IN EYE(S)
18. DEAFNESS OR HEARING
19. NOSEBLEEDS
20. SINUS PROBLEMS
21. NOSE PROBLEMS
22. DENTAL PROBLEMS
23. HOARSENESS
24. TONSILLECTOMY

GASTROINTESTINAL

25. POOR APPETITE
26. POOR DIGESTION
27. DIFFICULTY SWALLOWING
28. BELCHING OR GAS
29. FREQUENT NAUSEA
30. VOMITING
31. VOMITING BLOOD
32. PAIN OVER ABDOMEN
33. ULCER
34. BLACK OR BLOODY STOOL
35. LIVER PROBLEMS
36. GALL BLADDER PROBLEMS
37. JAUNDICE
38. HERNIA
39. DIARRHEA
40. CONSTIPATION
41. HEMORRHOIDS
42. APPENDICITIS

MEN ONLY

43. TESTICULAR SWELLING/PAIN
44. PROSTATE

RESPIRATORY

45. DIFFICULTY BREATHING
 46. CHRONIC COUGH
 47. SPITTING PHLEGM
 48. SPITTING BLOOD
 49. WHEEZING/ASTHMA
 50. PNEUMONIA
 51. TUBERCULOSIS
- ### CARDIOVASCULAR
52. IRREGULAR HEARTBEAT
 53. HIGH BLOOD PRESSURE
 54. PAIN OVER HEART
 55. PREVIOUS HEART TROUBLE
 56. ANKLE SWELLING
 57. VARICOSE VEINS
 58. RHEUMATIC FEVER
 59. STROKE

GENITOURINARY

60. FREQUENT URINATION
61. PAINFUL URINATION
62. BLOOD IN URINE
63. KIDNEY DISEASE
64. URINARY INFECTION
65. INABILITY TO CONTROL URINE
66. DIFFICULTY STARTING URINE
67. GET UP A NIGHT TO URINATE
68. BREAST LUMP OR PAIN
69. VENERAL INFECTION
70. SEXUAL DIFFICULTIES

SKIN

71. ITCHING
72. BRUISING EASILY
73. CHANGE IN MOLE(S)
74. SKIN CANCER
75. SCARS LOCATION

NEUROLOGIC

76. WEAKNESS
77. TWITCHING
78. TREMORS
79. HEADACHE
80. FAINTING
81. DIZZINESS
82. CONVULSIONS
83. EPILEPSY/SEIZURES
84. NUMBING/TINGLING
85. ARM/LEG PAIN
86. MENTAL DISORDER

MUSCULOSKELETAL

87. NECK STIFFNESS/PAIN
88. PAIN BETWEEN SHOULDERS
89. LOW BACK PAIN
90. SWOLLEN JOINTS
91. PAINFUL JOINTS
92. MUSCLES ACHES/SORENESS
93. SPINAL CURVATURE
94. ARTHRITIS

WOMEN ONLY

95. PAINFUL PERIODS
96. EXCESSIVE FLOW
97. IRREGULAR CYCLES
98. VAGINAL BURNING/ITCHING
99. HOT FLASHES
100. DATE LAST PERIOD BEGAN
101. DATE OF LAST PAP SMEAR

EXERCISE

102. NONE

103. 1-2 TIMES/WEEK

104. 3-5 TIMES/WEEK

105. 6-7 TIMES/WEEK

HABITS

106. SMOKING _____ #PACKS, DAY

107. DRINKING

108. RECREATIONAL DRUG USE

109. CAFFEINE

FAMILY HISTORY: BROTHERS,
SISTERS, PARENTS, GRANDPARENTS.

110. DIABETES

111. THYROID DISEASE/GOITER

112. TUBERCULOSIS

113. KIDNEY DISEASE

114. HIGH BLOOD PRESSURE

115. HEART DISEASE

116. CANCER

117. MUSCLE, BONE, NERVE DISEASE

118. LUNG DISEASE

119. ULCERS

120. ARTHRITIS

121. SEIZURES/STROKE