CONFIDENTIAL PATIENT INFORMATION

Today's date _____, _____

Name _____ Birth date _____ Age _____
Home phone _____ Cell _____ Email _____
Street _____ City _____ State ___ Zip _____
Employment (circle): Full-time Part-time Retired Student Social Security _____
Occupation_____ Employer_____ Work Phone _____
Driver's License #_____ Emergency Notification Person _____
Relationship to you _____ their Phone _____ Address _____
Is condition related to (circle): Employment Auto Accident Accident Date _____
Lost any days from work? (circle): Yes No On Disability (circle): Yes No
How did you learn about our clinic, or who referred you?_____

MAJOR CONCERNS

What are your main health concerns? How long you have had them, or the reason for appointment:

_____
Major stressors just prior to symptoms _____
Have you ever had the same or similar conditions? (circle): Yes No First onset _____
Names of recent doctors consulted _____ Dates_____
Date of last thorough checkup _____ What do you believe is wrong? _____
_____

PAST MEDICAL HISTORY

Serious Illnesses _____
Surgeries _____
Major accidents _____
Hospitalizations _____
Mental / Emotional Illness _____ How many close friends have you? ____
Medications & Supplements _____
Allergies: Medications, Inhalants, Foods _____
Major Childhood Illnesses _____
Chemicals, fumes, dusts, pets, radiation, etc. to which you are repeatedly exposed
_____
Immunizations _____ Describe scars you have _____
How many hours do you sleep at night? _____ How often do you awaken refreshed?_____
How many glasses of water do you drink daily? _____ Is this enough for you? _____
What is your energy on a scale of 1-10? (1 = lowest, 10 = the most energy imaginable) _____

Are you seeking a specific therapy? _____

For Dr. Ruhland to fill out			
Height	Weight	BP	Pulse

Circle medications you currently take:

- ■ Antacids
- ■ Antibiotics/Antifungals
- ■ Antidepressants
- ■ Antidiabetics/Insulin
- ■ Aspirin/Tylenol
- ■ AntiHypertensives
- ■ Chemotherapy
- ■ Cholesterol
- ■ Cortisone/ Anti-inflammatories
- ■ Decongestants
- ■ Diuretics
- ■ Hormones
- ■ Laxatives
- ■ Oral Contraceptives
- ■ Radiation
- ■ Relaxants
- ■ Sleeping Pills
- ■ Recreational Drugs
- ■ Thyroid _____
- ■ Ulcer Medications
- ■ Other _____
  _____

I eat, drink or use (circle):

- ■ Alcohol
- ■ Candy
- ■ Carbonated Beverages
- ■ Cigarettes
- ■ Coffee
- ■ Filtered Water
- ■ Fluoridated Water
- ■ Chlorinated Water
- ■ Regularly Eat at Fast Food Restaurants
- ■ Fried Foods
- ■ Refined (White) Flour Products
- ■ Dairy Products
- ■ Luncheon Meats
- ■ Margarine
- ■ Sugars
- ■ Artificial Sweeteners
- ■ Non Herbal Teas
- ■ Vitamins and Minerals
  Specify:
  _____
- ■ Special Diet (be specific)
  _____
  _____

Do you? (circle):

- ■ Diet often
- ■ Have much stress
- ■ Salt food without tasting
- ■ Exercise less than 3 times weekly
- ■ Think you are or have been exposed to toxins
- ■ Think you need help with your diet

I am (circle):

- ■ Warmer than others
- ■ Chillier than others

FAMILY HISTORY

Please identify any family members who have had any of the following:

Abbreviations: Self (Self), Parent A (PA), Parent B (PB), Sibling (Sib), Grandparent (G), Your Children (C)

	Self	PA	PB	Sib	G	C
Smoking	□	□	□	□	□	□
Alcoholism	□	□	□	□	□	□
Allergies	□	□	□	□	□	□
Anemia	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Birth Defects	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Ear Infections	□	□	□	□	□	□
Epilepsy/Seizures	□	□	□	□	□	□
Hearing Loss	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□

	Self	PA	PB	Sib	G	C
High Blood Pressure	□	□	□	□	□	□
Hypoglycemia	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□
Memory Loss	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□
Pneumonia	□	□	□	□	□	□
Strep Throat	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Thyroid Disorder	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□
Other_____	□	□	□	□	□	□
Other_____	□	□	□	□	□	□

Age and cause of parents' death: _____

MENTAL / EMOTIONAL HEALTH HISTORY

What do you consider strong points in your health or life? _____

_____

What is a typical day like for you? _____

_____

Relationship History: (circle) Single Partner Widowed Years in longest relationship _____
No. of Children ___ Ages of children _____
Is there anyone you are afraid of? _____
Do you use a contraceptive? (circle): Yes No What type? _____
First day of last menstrual period _____ Last Pap Test: _____
Are you pregnant? (circle): Yes No Not Sure
What are your main stressors? _____

REVIEW OF SYSTEMS

Please CHECK the items from which you have suffered:

□ Food Allergies	□ Foot Trouble	□ Ear Noises	□ Bed-wetting
□ Hay Fever	□ Low Back Pain	□ Deafness	□ Frequent Urination
□ Difficult Breathing	□ Neck Pain or Stiffness	□ Enlarged Thyroid	□ Kidney Infections or Stones
□ Asthma	□ Poor Posture	□ Failing Vision	□ STD's
□ Pleurisy	□ Sciatica	□ Bruise Easily	□ Prostate Problems
□ Frequent Colds	□ Scoliosis	□ Nosebleeds	□ Cramps or Backache
□ Sinus Infections	□ Swollen Joints	□ Varicose Veins	□ Excessive menstrual Flow
□ Dizziness	□ Colon Trouble	□ Low BP	□ Hot Flashes
□ Fatigue	□ Gas / Bloating	□ Heart Pain	□ Irregular Cycle
□ Headaches	□ Constipation / Diarrhea	□ Chest Pain	□ Breast Lumps
□ Insomnia	□ Difficult Digestion	□ Poor Circulation	□ Yeast / Candida Infection
□ Anxiety	□ Hemorrhoids	□ Rapid Heart-rate	□ Acne / Eczema
□ Depression	□ Ulcers	□ Heart Murmur	□ Mercury Fillings (how many?) __
□ Head Injury	□ Nausea	□ Irregular Heart-rate	□ Root Canals (how many?) ____
□ Learning Disorder	□ Vomiting Spells	□ Slow Heart-rate	
□ Numbness	□ Jaundice	□ Swollen Ankles	

Of those <u>checked</u> conditions above, please CIRCLE those from which you currently suffer.

I currently have tingling or numbness in:

□ Shoulders □ Elbows □ Arms □ Hands □ Fingers □ Hips □ Knees □ Legs □ Feet □ Toes

Do you have any other problems you would like to discuss?

_____

_____

If you could, would you be willing to improve your health by making simple changes in living habits? (circle): Yes No

If there is one main health concern we could help you with today, what should it be?

_____

_____