Inner Ocean Center for Healing

Patient Information:

Name: _____ Date: _____

Age: _____ Date of Birth: _____

Address: _____

Primary Phone: _____ Home Work Cell

OK to leave a message? Yes or No

Email: _____

Occupation: _____ Student? Yes No

Referred By: _____

* If patient is a child, please list parent's name here:

_____

Emergency Contact Information

Name: _____

Phone: _____

Primary

Physician_____

Phone_____

Fax_____

- What are your long and short term goals here?

- What is your primary complaint or complaints?

- When did the symptoms begin?

- What precipitated or started the condition?

- Does anything make it better or worse? (i.e. time of day, heat/cold, activity, season of the year, emotion, or position)

- Is it worse on one side of the body?

- Can you think of any other complaints or problems, even though they may seem insignificant or be unrelated to your primary complaint(s)?

- Please list any prior surgeries or hospitalizations and their date:

- Do you have any allergies (food, environmental, seasonal, etc.)?

Please check the appropriate box for each condition/symptom listed below:

Legend
C = Currently experiencing this
P = Past (experienced this in the past, but not currently)
B = Both (experiencing this currently and experienced this in the past)
N = Never experienced this

Condition/Symptom/Experience	**C**	**P**	**B**	**N**
Pain, palpitations, tightness or other sensations in your chest				
Shortness of breath				
Aches or pain in your neck, middle back, or low back				
Pain, numbness, or tingling in your arms or legs				
Injury or car accidents				
Concussion or hitting your head				
Eating disorders such as bulimia, anorexia, or compulsive eating				
Heartburn or nausea				
Distress in upper abdomen or stomach				
Diarrhea or loose stools				
Constipation or having less than one bowel movement per day				
Problems with gas or belching				
Burning, pain, or urgency with urination (or if male, with ejaculation)				
Sexually transmitted infections (i.e. HPV, gonorrhea, herpes, etc.)				
Exposure to chemicals, pesticides, etc.				
Physical, sexual, or emotional abuse				

Do you get headaches? Yes No

If Yes, how often: _____ and

Where on your head: _____

Do you have any tattoos? Yes No (If Yes, when did you get them: _____)

Have you ever had a blood transfusion? Yes No

Have you ever served in the military? Yes No

Do you ever cry? Yes No (If Yes, do you want to: be alone or be comforted)

Do you bite your nails? Yes No

Is it extremely important for you to be on time? Yes No

What is your predominate emotion? Joy Anger Fear Sadness

Do you have a regular exercise program? Yes No

If Yes, how many days per week: _____ and what type/intensity of exercise: _____

For Females:

Do you have an irregular period? Yes No

Before your period, do you have:

Breast tenderness? Yes No

Cravings? Yes No

Bloating? Yes No

Irritability? Yes No

Night sweats? Yes No

During your period, do you have:

Painful cramps? Yes No

A heavy flow? Yes No

Clots? Yes No

How many days is your typical cycle? _____

How many days of flow do you have? _____

Have you ever been pregnant? Yes No

If Yes, how many times have you had:

A live birth: _____ A miscarriage: _____ An abortion: _____

<u>Sleep Habits</u>

Do you sleep well? Yes No

How many hours a night do you sleep? _____

Do you take naps? Yes No (If Yes, how many or how long: _____)

What position do you sleep in at night? Back Stomach Side Other: _____

Do you remember your dreams every morning upon waking? Yes No

Do you drool on your pillow at night? Yes No

Eating Habits

Do you eat the following:

Dairy products (milk, yogurt, cheese, etc.)? Yes No

Red meat (beef, venison, lamb, pork)? Yes No (circle each type)

Fish or fowl (tuna, salmon, chicken, turkey)? Yes No (circle each type)

Eggs? Yes No (If Yes, Free Range or Caged)

Commercially canned food? Yes No

Fruit or vegetable juice? Yes No

Products made with flour (pasta, bread, cereal, etc.)? Yes No

Vegetables and legumes? Yes No

Fruit? Yes No (If Yes, how many pieces/day? _____)

Whole grains (brown rice, millet, oats, etc.)? Yes No

Soy products (tofu, soy milk, tempeh)? Yes No

Please mark how often you consume these items:

- Spoon of sugar: _____
- Soda/Soft Drinks: _____
- Pastries/Donuts: _____
- Cookies/Cake: _____
- Ice Cream: _____
- Coffee: _____
- Alcohol (list type and quantity):

  _____
- Recreational Drugs (list type and quantity):

  _____

Diet Diary

Please list EVERYTHING you EAT and DRINK for three (3) full days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			
Water			

Medications and Supplements

Please list your current prescription medications and their dosages:

Please list any vitamins, minerals, or supplements that you take:

Lifestyle Questions

Do you sleep on a waterbed? Yes No

Do you use an electric blanket**?** Yes No

What kind of water do you typically drink? Filtered Bottled Tap

Do you use anti-perspirant? Yes No

Do you smoke or chew tobacco? Yes No (If Yes, how much/day? _____)

Have you regularly smoked or chewed tobacco in the past? Yes No

Patient History & Timeline

In the space below, please write out a brief timeline of your history.

(Begin with your birth and early childhood, include any major illnesses, injuries, or hospitalizations, and continue up to the present time. Be sure to list significant turning points or major events in your life. Also include any periods of heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. For women, please include events related to your reproductive system such as first period, birth control, pregnancies, miscarriages, abortions, and menopause. If you are filling this out for your child, please include specific information about their pregnancy, birth, and breastfeeding experiences.)

Family History

Please list any ailments that have affected your relatives. (If you were adopted, please complete this section based on any known information about your biological family.) Please list your relatives current age, or age they were at death.

Relative	Ailment	Age
Mother		
Father		
Brother(s)		
Sister(s)		
Maternal Grandmother		
Maternal Grandfather		
Maternal Aunts/Uncles		
Paternal Grandmother		
Paternal Grandfather		
Paternal Aunts/Uncles		

Do you have a spouse/partner? Yes No

If Yes, please list their name, age, occupation, significant health information:

Do you have any children? Yes No

If Yes, please list their names, ages, significant health information:

Do you have any pets? Yes No

If Yes, please list their name and type of animal:

Thank you for taking the time to complete this questionnaire. Please remember to bring this with you to your initial appointment. If you have questions about this form or your appointment, please call: 720-441-2392.