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PERSONAL INFORMATION:
First Name:___________________________Last Name:________________Middle Initial: ____________________
Email for doctor communications: ______________________________ Age: ________ Birth Date: __________
Female / Male Place of Birth:___________________________
Race/National/Ethnic Roots: ____
Right Handed / Left Handed / Mixed Dominance

SOCIAL HISTORY
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Religious Preference:
Where do you live: House ☐ Apartment ☐ Nursing Home ☐ Assisted living ☐ Homeless ☐
Who lives with you?:
Work status: (check one) Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐
Current and prior occupations:
Highest level of education:
Age and gender of children (if any):

GENERAL:
Who can we thank for referring you? _________________________________
What do you hope to get from today's visit?
____

PLEASE DESCRIBE YOUR PRIMARY HEALTH CONCERNS

Is the condition due to injury or sickness arising out of employment? ____________
Is the condition due to injury or sickness arising out of an auto or other type of accident? _
Number of days lost from work _______________ Date symptoms appeared or accident happened __________________
1. What are the primary problems you are experiencing? ____
____
____
____
2. In the past have you ever had the same or a similar condition? ___yes ___no If yes, please describe: ________________
____
____
3. Has it changed recently? ___Better ___Worse ___Same What types of treatment have you tried? ____________
____
What makes it better? ____
Worse? ____
4. How frequent is the condition? __________________________________ How long does it last? ____________________
5. Is this affecting your sleep? ___Yes ___No If yes, please describe: ____

Is this affecting your ability to perform your job or daily activities? ____Yes _____ No If yes, please describe: _

____

6. Are there any other symptoms that may be related to these concerns, which you have not listed? ___Yes ___No
If yes, please describe:

____

____

Please list all doctors you have seen related to your current concern, also please include any chiropractors or family medical doctors. If possible list the approximate date of the last visit and their city and telephone number.

1. ____
2. ____
3. ____
4. ____

Please describe any previous tests (X-ray, MRI, EKG, blood work, etc.) to investigate your current problems.

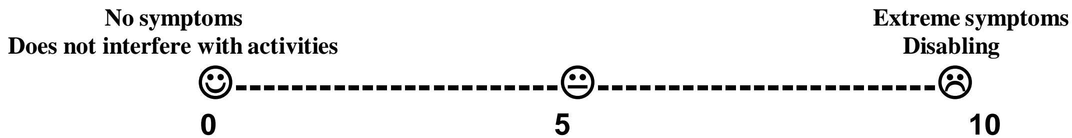
____

____

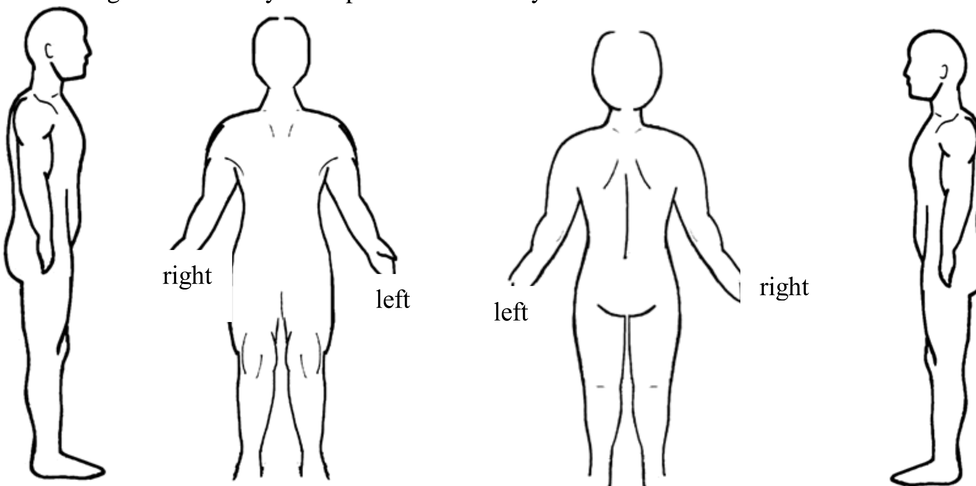
____

____

Please mark an "X" on the line to indicate the severity of your condition:



Please mark any areas of concern on the diagrams below. N – Numbness P- pins & needles B- burning A- aching S-stabbing. Indicate any other problems as best you can.



Major Health Problems with brief description	Date of Onset	Frequency (Daily, weekly)	Severity (mild, mod or severe)
1.			
2.			
3.			
4.			

OTC & Prescription Medications	DOSEAGE and # per day	Good Response	No Response	Bad Response	Bad then Good

Allergies (either to medications, substances, airborne)

I hereby authorize payment directly to Pinnacle Natural Health Center for insurance benefits. I understand I am financially responsible for all services rendered to the patient. Patient balances are to be paid at the time of service. I hereby give my express written consent to Pinnacle Natural Health Center and any of it's agents to communicate with me regarding my account(s) through various means of communication including but not limited to cellular phone, landline, text or similar electronic devices. This express consent is given in order to permit Pinnacle Natural Health Center to more easily communicate regarding any issue; including for purposes of billing, insurance and collection of any balance due.

Signature: ____ Date: _________________

DIETARY HISTORY

Check the most appropriate description below of my diet:
_______________Mostly carbohydrates (bread, pasta, etc.)
_______________Mostly dairy (milk, cheese, etc.)
_______________Mostly meat
_______________Mostly vegetarian (vegetables, fruits, grains, etc.)
Other Describe: ____

Are you on a Gluten Free Diet____Yes____No
Are you on a Dairy Free Diet____Yes____No
Have you benefited by being on this diet? ____
Are you on a Low Carbohydrate Diet? __________
Are you on high Omega 3 fatty acid supplementation?____Yes____No. Any benefits?__________________

Please list the foods and beverages normally consumed by you for three typical days:

DAY 1

Breakfast: ____
Morning snack(s): ____
Lunch: ____
Afternoon snack(s): ____
Dinner: ____
Other ____

DAY 2

Breakfast: ____
Morning snack(s): ____
Lunch: ____
Afternoon snack(s): ____
Dinner: ____
Other ____

DAY 3

Breakfast: ____
Morning snack(s): ____
Lunch: ____
Afternoon snack(s): ____
Dinner: ____
Other ____

DIGESTIVE HEALTH

Do you have periodic loose stools/diarrhea _____Yes _____No Offensive Gas_Yes______No
Undigested Food in Stools____Yes____No Offensive Breath____Yes No
Do you suffer with acid reflux/heartburn____Yes____No
Are you currently taking an acid-blocking medication such as Tagamet, Pepcid, etc.____Yes____No
Do your digestive problems occur more with stress____Yes _____No _____Unsure
Do you produce well formed stools____Yes___No
Have you ever produced formed stools___Yes____No

ANTIBIOTIC HISTORY

How many courses of antibiotics have you received in lifetime (approx): 0 1-5 _____5-10 _____10-15 _____15-20 _____20+
Main reason for antibiotic use: _____Ear Infections _____Bronchitis _____Pneumonia _____Sinus Infection _____Intestinal Infection________Other (please explain)________________ Have you ever been treated for a yeast infection following antibiotic use _________________

Survey of Your Health History

Please circle all that apply. Indicate whether this is a Current (C) or Past (P) concern also provide an approximate date for past concerns. Indicate severity with 1 mild, 2 moderate, 3 severe.

1. General
Fever
Night sweats
Nervous ness
Bleeding
Diabetes
Thyroid
Headache
Fainting
Depression
Memory loss
Chills
Fatigue
Weight loss/gain
Anemia
Cancer
Substance abuse
Dizziness
Seizures
Phobias
Waking in night
Problems falling asleep
Explain any surgeries or hospitalizations: _______________

____

____

Any broken bones, car accidents or other injuries? ________________

____

2. Gastrointestinal
belching/gas
vomiting
bloody stools
hernia
constipation
diarrhea
abdominal pain
nausea
liver problems
other_________________________

3. Respiratory
breathing problems
spitting phlegm/blood
allergies
asthma
shortness of breath
chronic cough
pneumonia
other ________________________

4. Cardiovascular
irregular heartbeat
racing heart
chest pain
high blood pressure
swelling
prior heart problem
pacemaker
stroke
other ________________________

5. Musculoskeletal
stiffness
pain
swelling
spinal curve
arthritis
weakness
twitching
tremors
numbness
other ________________________

6. Skin
rashes
mole changes
itching
nail changes
redness
other ________________________

7. EENT
blurry vision
double vision
eye pain
jaw pain
hearing loss
ringing in ears
ear infection
sinus problems
nosebleeds
throat problems
speech problems
Glasses or contacts? _______

8. Genitourinary
frequent/painful urination
incontinence
blood in urine or stool
urinary infection
venereal infection
other ________________________

9. Women Only
difficult periods
hot flashes
irregular cycles
breast pain
lump in breast
difficulty becoming pregnant
complications of pregnancy
other ________________________
Date last period ended __________
Date last gynecologic exam ______

10. Men Only
testicular pain
prostate problems
difficult erection
low sperm count

11. Exercise
none
1-2 per week
3-4 per week
5-7 per week
What type? ___________________

12. Habits
Smoke (___packs/day, years?____)
Alcohol (________drinks per wk)
Caffeine (________cups per day)
Recreational drug use ___________

13. Family
Are your parents living? _______
If so do you consider them to be in good health? ______________________
Ages: Mother______Father ______

Circle any below that apply to your parents, grandparents, siblings or children:
Diabetes
Stroke
Hypertension
Cancer
Seizures
Tremors
Brain disorder
Heart disease
Lung disease
Arthritis
Scoliosis