Illuminate
NATURAL HEALTH

NAME:_____ **DOB:** _____

PARTNER NAME: _____ **DOB:** _____

Phone: _____ Email: _____

Address: _____

_____

Emergency contact: _____

How did you hear about our clinic? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____

IF NOT, WHEN DID YOU LAST RECEIVE HEALTH CARE?_____

WHAT WAS THE REASON?_____

Allergies: _____

Height: _____ Weight: _____ Maximum Weight ever: _____

Blood Type: _____

OCCUPATION: _____

PREVIOUS OCCUPATIONS: : _____

_____

Health History

Past medical diagnoses w/ dates : _____

_____

_____

Past medical diagnoses w/ dates (Partner): _____

_____

_____

Family health history: _____
_____
_____

Family health history (Partner):
_____
_____

Medications:
_____
_____
_____
_____

Supplements:
_____
_____
_____
_____

LIFESTYLE

Exercise? _____ What kind? _____ How often?_____

Sleep

How many hours?_____Wake during night? _____ Hard to fall asleep? _____ Awake rested? _____

Do you enjoy your work?_____ Take vacations? _____

Do you work night shift?_____

If so, describe you sleeping schedule through week: _____

_____

Do you have a spiritual practice?_____

3 Day Diet recall (Him/Her)

	Breakfast	Lunch	Dinner	Snacks	Beverages
Day 1					
Day 2					
Day 3					

Do you avoid any particular foods?

Substance	Current Use	Amount	Frequency	Past Use	Length of Use
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Pain Killers					
Tranquilizers					
Inhalants					
Sleeping Pills					
Diet Pills					
Laxatives					
Steroids					
Methamphetamines					
PCP/LSD/Mushrooms					
Ecstasy					
Cocaine/Crack					
Heroin					

REVIEW OF SYSTEMS:

Circle/highlight if the condition or symptoms are a present concern.
*Mark **P** for those you have experienced in the past.*

IMMUNE

Chronic Fatigue

Chronic Swollen Glands

Lyme disease

Autoimmune

Chronic infections

Slow Healing
Frequent colds
Hay fever

ENDOCRINE

Hypothyroid

Hypoglycemia

Excessive thirst/hunger

Fatigue

Heat or Cold Intolerance

Diabetes

MENTAL/EMOTIONAL

Seasonal depression

Depression

Anxiety

Stress level 0-10 =6

Easily stressed

Mental illness diagnosis

Counseling/therapy P

Have you ever attempted suicide?

Are you currently contemplating suicide?

NEUROLOGICAL

Seizures

Muscle Weakness

Loss of Memory

Vertigo/ Dizziness

Loss of balance

Paralysis

Numb/Tingling

Headaches/ Migraines

Head injury / TBI

Loose consciousness?

Age? #?

SKIN

Rashes

Acne

Lumps

Skin color change

Eczema

Hives

Itching

Hair loss

Night sweats

EYES

Spot in eyes

Impaired vision

Color blindness

Double vision

Cataracts

Glasses/Contacts

Eye pain

Tearing/ dryness

Glaucoma

NOSE/SINUSES

Stuffiness

Nose bleeds

Loss of smell

NECK

Lump

Goiter

Pain/Stiffness

Swollen glands

RESPIRATORY

Cough

Sputum/Phlegm

Cough up blood

Asthma

Pneumonia

Pain with breathing

Shortness of breath (SOB)

GASTROINTESTINAL

Heartburn

Abdominal pain

Constipation

Diarrhea

Black/Bloody stools

Undigested food in stools

Bloating

Hemorrhoids

How often are you having bowel movements?

Food sensitivities

Rashes from foods

MOUTH/ THROAT

Frequent sore throat

Teeth grinding

Gum problems

Cavities

Sores in mouth

Hoarseness

TMJ pain/ clicks

Dry mouth

Excess saliva

CARDIOVASCULAR

Heart disease

Ankle swelling

High/Low blood pressure

Phlebitis

Blood clots/ Deep vein thrombosis

Angina

Murmurs

Irregular heartbeat/ flutter/palpitations

Dizzy when standing

Chest pain

Easy bleeding/bruising

Varicose veins

URINARY

Pain with Urination

Urinate at night

Frequent urination

Frequent infections

Incontinence

Kidney stones

MUSCULOSKELETAL

Pain or stiffness

Muscle spasm or cramps

Arthritis

Weakness

Sciatica

FEMALE REPRODUCTIVE

Age of first menses

Length of cycle

Duration of menses

Day of last menses

Painful menses/Clotting/ Heavy flow

Breast pain or tenderness/ Lumps

PMS

Nipple discharge

Endometriosis

Ovarian cysts

Cervical dysplasia

Pain with intercourse

Birth control:
How long? What Type?

MALE REPRODUCTIVE

Hernias

Testicular pain

Discharge/ sores

Premature ejaculation

Testicular mass

Prostate disease

Impotence

FERTILITY HISTORY

Trying to conceive for: _____

Pregnancies: _____ Live births: _____

Elective abortions: _____ Spontaneous abortions/ miscarriage: _____

What stage of pregnancy did miscarriages occur? _____

IUI attempts: _____ IVF attempts: _____

# of hormone supported cycles: _____

Method of tracking cycles/ovulation: _____

Frequency/ Timing of intercourse: _____

Sexual problems:

Male: Premature ejaculation, erectile dysfunction, _____

Female: painful intercourse, vaginal dryness, _____

OB/GYN/Midwife/Infertility specialists: _____

RECENT LAB TEST RESULTS:
TSH

DAY 3 Hormones:

Estradiol

FSH

LH

Prolactin

Testosterone

DAY 21 Hormones:

Progesterone

Immunological tests: