



**PERSONAL INFORMATION**

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

\*\* Please circle the phone number you wish to be contacted with results.  
May we leave a voice message on that phone with your results? YES NO

HOME PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL (\_\_\_\_) \_\_\_\_ - \_\_\_\_ WORK (\_\_\_\_) \_\_\_\_ - \_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX  F  M SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ (will NOT be shared)

PRIMARY CARE DOCTOR \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_

MARITAL STATUS:  SINGLE  DIVORCED  LEGALLY SEPARATED  PARTNER  
 MARRIED (SPOUSE NAME \_\_\_\_\_)  WIDOWED  UNKNOWN

EMPLOYER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

EMPLOYMENT STATUS:  FULL TIME  NOT EMPLOYED  RETIRED  PART TIME  
 SELF EMPLOYED  ACTIVE MILITARY

STUDENT STATUS:  FULL TIME  PART TIME

**RESPONSIBLE PARTY:**  SELF  GUARANTOR RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**EMERGENCY CONTACT:**

NAME LAST \_\_\_\_\_ FIRST \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

THEIR HOME PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_ THEIR WORK PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION TO:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**PHARMACY:**

NAME \_\_\_\_\_ LOCATION \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_ FAX (\_\_\_\_) \_\_\_\_ - \_\_\_\_

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize *Crabapple Integrative and Internal Medicine* and my insurance company to release any information required to process my claims.

Patient or Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**What brings you to see the clinic today?**

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**What are your most important health concerns (Top 3)?**

- 1)
- 2)
- 3)

**How did you hear about our clinic?**

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**Medical History**

Please list all previous diagnoses of any medical conditions:

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**Hospitalizations:**

What hospitalizations or surgeries have you had? \_\_\_\_\_

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**Imaging:**

What diagnostic imaging studies have you had?  X-rays  CT scan  PET scan  MRI  
 Endoscopy  Colonoscopy  Sigmoidoscopy  Bone density scan  Mammogram  
 EKG/ECG  EEG

Were there any significant findings?

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**Allergies:**

Are you aware of any **allergies** to food, drugs, or other environmental allergens (cats, mold, and dust)? If yes, please list and explain:

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**Childhood Illnesses**

Please circle whether you have/had any of the following conditions:

Diphtheria	Mumps	Polio	Rubella
German measles	Rheumatic fever	Pertussis	Chronic Ear or Throat
Measles	Scarlet fever	Chicken Pox	infections
Tuberculosis	Other _____		

**Past Immunizations**

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria	Polio	Hepatitis A/ B
Measles/Mumps/Rubella (MMR)	Tetanus	HiB
Pertussis	Varicella (Chicken Pox)	Influenza; annually? Yes / No
Other(s) _____		

**Family History**

*Do you have a family history of any of the following (please circle)?*

Anemia	Diabetes	Goiter	Kidney disease
Arthritis	Epilepsy	Hay fever/hives	Liver disease
Asthma	Gall bladder disease	Heart disease	Mental illness
Cancer	Glaucoma	Heart murmur	Stroke
Cataracts	Gluten Sensitivity	High blood pressure	Tuberculosis

Is your father still living? Yes; his age \_\_\_\_\_ No; age at time of death \_\_\_\_\_ Cause of death \_\_\_\_\_

Is your mother still living? Yes; her age \_\_\_\_\_ No; age at time of death \_\_\_\_\_ Cause of death \_\_\_\_\_

**Review of Systems**

*Please circle. Y= Yes, present condition P=Problem of the past N=No, never had the condition.*

**Head**

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

**Ear**

Ringings	Y P N	Dizziness	Y P N	Frequent wax build up	Y P N
Earaches	Y P N	Impaired hearing	Y P N	Itchy or moist ears	Y P N

**Eyes**

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N

**Nose/Sinuses**

Stuffiness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hayfever	Y P N	Nose bleeds	Y P N	Frequent discharge	Y P N

**Mouth/Throat**

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N
Dry Mouth	Y P N				

**Neck**

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

**Skin**

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

**Respiratory**

Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N
Tuberculosis	Y P N	Difficulty breathing while lying down at night	Y P N		

**Cardiovascular**

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressr	Y P N
Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

**Gastrointestinal**

Diarrhea	Y P N	Constipation	Y P N	Ulcers	Y P N
Black stool	Y P N	Coughing up blood	Y P N	Jaundice	Y P N
Hemorrhoids	Y P N	Gall bladder disease	Y P N	Heartburn	Y P N
Abdominal pain	Y P N	Blood in stool	Y P N	Liver disease	Y P N

How many bowel movements per day? \_\_\_\_\_

Are they generally: loose well-formed dry and hard pebble-like

**Urinary**

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequency at night	Y P N	Change in color / odor	Y P N

**Musculoskeletal**

Joint pain	Y P N	Muscle spasms	Y P N	Stiffness	Y P N
Arthritis	Y P N	Muscle pain/soreness	Y P N	Broken bones	Y P N
Sciatica	Y P N	Muscle weakness	Y P N		

**Neurological**

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

**Emotional**

Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Loss of loved one	Y P N

**Endocrine**

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

**Male Reproductive**

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Premature Ejaculation	Y P N	Sexually transmitted disease/infections	Y P N	Blood in semen	Y P N

**Female Reproductive**

Age of first menses \_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_

Length of cycle \_\_\_\_\_

Duration of menses \_\_\_\_\_

Date of last gynecological annual exam \_\_\_\_\_

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N

Breast tenderness	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N
Birth control	Y P N	If yes, what type?	_____		
Number of pregnancies	_____		Number of live births	_____	
Number of miscarriages	_____		Number of abortions	_____	

**Environmental**

Circle any of the following you routinely use at home: *Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket T.V. Distilled/ Filtered/ Spring/ Well/ Deionized/ Tap water*  
 Is your home and work environment well ventilated?

\_\_\_\_\_

Is your home or work environment excessively damp or moist?

\_\_\_\_\_

Has there been any known mold growth, leaks, or large spills in your home or place of employment?

\_\_\_\_\_

Please circle any of the following you feel most bothered by:  
*Sunshine Lack of sunshine Dampness Dryness Cold Heat Seashore Mountains New Moon Full Moon Dust/Mold Cat or Dog hair Car fumes Poor air/ventilation Spring Summer Fall Winter Change in weather (specify) Wind Approach of a storm Fluorescent lighting Chemicals Other (specify)*

\_\_\_\_\_

Do you get outdoors daily, even in the winter? \_\_\_\_\_

How do you feel about your work? Do you enjoy it, are you satisfied and fulfilled by it, does it provide you with the necessities of life, is it just a job you feel you must put in the hours in order to make a living?

\_\_\_\_\_

\_\_\_\_\_

Have you ever lived in or near an industrial area, waste management area, known environmentally contaminated area? \_\_\_\_\_

Have you ever worked with chemicals, pesticides, solvents, plastics, resins, metals, etc?

\_\_\_\_\_

Do any of your hobbies include the use of chemicals, pesticides, solvents, plastics, resins, metals, etc?

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Is there anything else you would like us know in order to serve you better?

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