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Date_____
Referred by_____
Sex at birth: Male Female

Please write clearly and answer the questions as succinctly as possible.

Name _____ Birth date _____ Age _____
Phone_____ Email_____
Cell phone_____ fax_____
Address_____City_____Zip_____
Employer_____
Single ____ Partnered/married ____ Name of partner_____
Person to contact in case of emergency _____
Phone number _____ relationship _____
General health: Good _____ Fair _____ Poor _____
Place of birth_____Raised_____
Travel outside USA, where? _____
Occupation_____
Exposure to: fumes, dust or chemicals (Specify) _____

Weight:_____ **Current height:** _____**Tallest Height:** _____**Menopause age:** _____

1. Your ethnicity (check one):
   __Caucasian (White) __Black __Aboriginal __Asian __Hispanic __Other

2. Have you had a recent weight change? Yes No
   If YES, tell us about it: _____

4. Have you ever broken a bone? Yes No

Bone broken	**Simple fall?**	**If not a simple fall, please describe the circumstances**	**Age when this occurred**

5. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

6. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

7. How many times have you fallen in the last year? _____ Yes No

8. Have you ever had surgery of the spine, hips, legs or arms? Yes No
If YES, describe what type of surgery you had and which side was affected

_____
_____
_____

9. List any chronic medical conditions that you have:

_____ _____
_____ _____
_____ _____

10. Are you currently receiving or have you previously received prednisone pills (cortisone)?
Yes, currently ____ Yes, previously _____ No ____
If YES, for how long? _____ What is your dose? _____mg or _____ pills each day

11. Are you currently taking or have you previously taken any of the following medications?

	No	Yes	For how long?
Medication for seizures or epilepsy			
Chemotherapy for cancer			
Medication for prostate cancer			
Medication to prevent organ transplant rejection			

12. Have you been treated with any of the following osteoporosis medications?

Osteoporosis Medication	Ever?	Currently?	From when to when
Hormone replacement therapy (Estrogen)			
Fosamax (Alendronate)			
Reclast (Zoledronic acid or Zometa)			
Boniva (Ibandronate)			
Didronel/Didrocal (Etidronate)			
Actonel (Risedronate)			
Prolia (Denosumab)			
Evista (Raloxifene)			
Calcitonin (Miacalcin nasal spray)			
Forteo - PTH ((Teriparatide)			
Strontium Ranelate			
Sodium fluoride (Fluotic)			
Other			

Other Medication	Ever?	Currently?	From when to when
Estrogen			
Testosterone			
DHEA			
Tamoxifen			
SSRIs – anti-depressant medication			
Intravenous pamidronate (Aredia)			
Clodronate (Bonefos, Ostac)			
Sodium fluoride (Fluotic)			

Proton Pump Inhibitors (Nexium, Prilosec)			
SSRIs – anti-depressant medication			

13. How many servings of the following do you eat/drink per day (on average)?

	Milk (full cup)	Orange juice fortified with calcium (full cup)	Yogurt (small container or ½ cup)	Cheese
Number of servings				

14. Do you take any calcium supplements (including TUMS)? Yes No

15. Do you take any vitamin D supplements Yes No

16. Do you smoke? Yes No

For women only…

17. Are you still having menstrual periods? Yes No

18. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

19. Have you had your menopause? Yes No
    If yes, at what age? _____

20. Have you had a hysterectomy? Yes No
    If YES, at what age? _____
    Have you had both of your ovaries removed? Yes No
    If YES, at what age? _____

Please list all supplements that you are taking. For a multi-vitamin just list the company name

Supplement Name and Company Name	**Dose**	**How many each day?**

Prescribed medications you are taking NOW and dosage:

_____ _____
_____ _____

List any over-the-counter medications and how often you take them:

_____ _____
_____ _____

Past medications you have taken and for how long (The list may include frequent use of ibuprofen or aspirin, corticosteroids, inhalers, hormones, antidepressants, sleep aids etc.):

_____ _____
_____ _____

Current Vitamin Supplements:

_____ _____
_____ _____

Current Herbs or any other supplementation:

_____ _____
_____ _____

Caffeine Tobacco and Alcohol use:

Alcohol (amount per week) _____

Tobacco (amount per week or day) _____

Caffeine – coffee, tea, sodas, chocolate (amount per week or day)_____

_____

Any past or present drug use: _____

_____

Allergies: _____

_____

_____

Medications/Foods/Other_____

_____

_____

Have you had any of the following exams:

Exam	Date	Result
Mammogram	_____	_____
Bone Density	_____	_____
Pap Smear	_____	_____
Thermography	_____	_____
Blood tests	_____	_____
Colonoscopy	_____	_____

Sigmoidoscopy	_____	_____
Biopsies	_____	_____
Dental exam	_____	_____
Physical exam	_____	_____
Blood pressure	_____	_____
Cholesterol	_____	_____

Other_____
_____

Family History:

Has anyone in your family had trouble with the following? Include mother (**M**), Father (**F**), sister (**S**), brother (**B**), grandmother (**GM**), grandfather (**GF**)

Yes	No	Not sure	
_____	_____	_____	Thyroid disease
_____	_____	_____	Diabetes
_____	_____	_____	Stroke
_____	_____	_____	High blood pressure
_____	_____	_____	Heart attack (include age of heart attack)
_____	_____	_____	High blood fats (Cholesterol)
_____	_____	_____	Respiratory problem/asthma
_____	_____	_____	Osteoporosis
_____	_____	_____	Alzheimer's disease
_____	_____	_____	Breast cancer
_____	_____	_____	Ovarian cancer
_____	_____	_____	Bowel cancer
_____	_____	_____	Other _____

If you were born between 1945 –1975 did your mother take diethylstilbesterol (DES) or other drugs to prevent miscarriages during her pregnancy with you?_____

Medical History

Have you had or do you now have any of the following:

Yes	No	Now	
___	___	___	Migraine headaches
___	___	___	Stroke/CVA
___	___	___	Epilepsy/Seizures
___	___	___	Visual problems/glaucoma
___	___	___	Asthma/Bronchitis/Emphysema
___	___	___	Liver disease/hepatitis
___	___	___	Gall bladder disease
___	___	___	Diabetes
___	___	___	Thyroid problems
___	___	___	Osteoporosis/osteopenia
___	___	___	Hormone problems
___	___	___	Kidney/bladder disorder
___	___	___	Bowel diseas

Symptoms:

Yes	No	Now	
___	___	___	Hot flashes/flushes
___	___	___	Perspiration, night sweats
___	___	___	Insomnia, sleeping difficulties
___	___	___	Heart palpitations
___	___	___	Nervousness, anxiety
___	___	___	Depression
___	___	___	Irritability, mood swings
___	___	___	Do you feel overwhelmed with your life
___	___	___	Dry skin
___	___	___	Hair loss or thinning (more hair in your brush)
___	___	___	Fingernail – brittle, dry or ridged
___	___	___	Cold or heat intolerance
___	___	___	Fatigue
___	___	___	High cholesterol
___	___	___	Memory loss, forgetfulness
___	___	___	Headaches, migraines
___	___	___	Weight gain
___	___	___	Weight loss
___	___	___	Bloating
___	___	___	Muscle or joint pain
___	___	___	Itchy, crawly or burning sensations in skin
___	___	___	Leg cramps
___	___	___	Heart disease/chest pains
___	___	___	Facial hair growth
___	___	___	Dizziness

Gastrointestinal Health:

Yes		Describe briefly
_____	Frequent gas or bloating	_____
_____	Indigestion	_____
_____	Stomach aches	_____
_____	Nausea	_____
_____	Constipation	_____
_____	Diarrhea	_____
_____	Irritable bowel syndrome	_____
_____	Food related problems	_____
_____	Candida/yeast infections	_____
_____	Other factors – parasites etc.	_____

Gynecological Health:

Yes	No	Now		Comments:
___	___	___	Breast tenderness	_____
___	___	___	Vulvar itching or burning	_____
___	___	___	Frequent urination	_____

___ ___ ___ Involuntary loss of urine_____
___ ___ ___ Vaginal dryness, decreased lubrication_____
___ ___ ___ Pain or bleeding during sexual penetration_____
___ ___ ___ Bladder infections _____
___ ___ ___ Yeast infections_____
___ ___ ___ Change in sexual interest/desire_____
___ ___ ___ Fibro cystic breasts_____
___ ___ ___ Breast lump/tumor/nipple discharge/surgery_____
___ ___ ___ Uterine tumors/fibroids/cancer_____
___ ___ ___ Hysterectomy _____
___ ___ ___ Ovarian tumors or cysts_____
___ ___ ___ Endometriosis_____
___ ___ ___ Vaginal discharge/infections/tumors_____
___ ___ ___ STD's (i.e. syphilis, herpes, etc.)_____
___ ___ ___ Any history of abnormal pap smears_____

Menstrual History:

_____ Age period started
_____ If you have stopped bleedin, the month or year of last period
_____ First day of last period if still menstruating
_____ Age periods became - irregular/painful/heavy/diminished flow (circle)
_____ How many days between periods
_____ How many days do periods last
_____ Has the length of your cycle increased or decreased in resent times
_____ Do you have bleeding or spotting between periods
_____ PMS? What are your symptoms and when in the cycle do they occur:
_____

Pregnancy History:

_____ Number of pregnancies
_____ Abortions
_____ Miscarriages/stillbirths
_____ Ectopic (tubal pregnancies)
_____ Premature births
_____ Live births
_____ Living children (ages): _____

Contraceptive History:

Are you currently sexually active? _____
Is your sexual life stressful or pleasurable_____ Could you be pregnant_____
Are you trying to get pregnant_____
Have you used birth control pills_____How long?_____
When was the last time you used birth control pills_____
Do you use any other method of birth control now_____
Are you practicing safe sex_____
Any problems or comments_____

Sleeping Health:

In general – are you getting enough sleep at night_____
How many hours of sleep do you sleep each night_____
How long does it take for you to fall asleep_____
What time do you go to bed_____
What activities do you do prior to bedtime_____
Do you wake up with an alarm clock or without alarm clock_____
Do you wake up tired_____
Is your sleep interrupted and if it is what causes the interruptions_____
_____
If you are having sleeping difficulties how long has this been so_____
Would you consider yourself a light sleeper_____
Are you taking anything to induce sleep_____

Surgeries: Date Type
_____
_____
_____
_____

Exercise and Your Body:

What is your current weight_____ Height_____
What is the body weight that you feel is best for you_____ Have you been on diets in the past to lose or gain weight_____
_____
How do you feel about your body fitness presently_____
Type of Aerobic exercise_____ How many times a week_____ Duration_____
Stretching_____ How many times a week_____
Weight training_____ How many times a week_____
Have you ever worked with a trainer_____ How many sessions_____
Are you satisfied with your exercise program _____
_____
Do you need some kind of support with your exercise program _____
_____

Emotional Health:

Do you feel connected in your life with friends and family _____
Do you feel connected spiritually (however you define that)_____
Do you regularly get out in nature_____
In general do you see the cup as half full or half empty _____
What do you do to reduce stress _____
Do you feel that you are depressed or anxious_____
Have you ever received counseling _____
If you have a primary relationship do you feel good about it _____
_____

How long have you been together _____

Are other stress factors affecting your life? (Financial, relationships, work, living-space)

_____

_____

Relationship with food:

How would you describe your present relationship with food_____

_____

Do you now have or have you in the past had an eating disorder _____

_____

_____

Do you have home cooked meals _____

Are your meal times relaxed for the most part or rushed _____

_____

Do you buy organic food

_____

Anything else about food? _____

_____

_____

How would you describe your energy level during the day:

	High	Low	Tired	Best	Comments
Morning	____	____	____	____	_____
Afternoon	____	____	____	____	_____
Evening	____	____	____	____	_____

List the alternative doctors/practitioners you have seen:

Yes	No	Last seen	
____	____	_____	Chiropractor
____	____	_____	Acupuncturist
____	____	_____	Homoeopathist
____	____	_____	Massage Therapist
____	____	_____	Psychotherapist
____	____	_____	Nutritionist
____	____	_____	Other_____

What are your primary concerns: (Please be brief)

_____

_____

_____

_____

_____

_____

Is there anything else that you want to communicate about your health?