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PATIENT INFORMATION

DATE : _____

NAME : _____ DATE of BIRTH : _____

MALE FEMALE

IF CHILD, PARENT'(s) NAME(s): _____

SS# (optional) _____

MAILING ADDRESS : _____
Street or PO Box #, City, State, Zip

PHYSICAL ADDRESS : _____

PHONE : Home _____ Work : _____ Email : _____

OCCUPATION / EDUCATION : _____

SPOUSE / SIGNIFICANT OTHER : _____ OCCUPATION : _____

CONTACT NAME & PHONE # for EMERGENCY : _____

PRIMARY PHYSICIAN : _____ PHONE : _____

What are the most important health concerns you have at this time ? *List in order of importance.*

Brief Description

When symptoms started

What do you think is causing them ?

1. _____
2. _____
3. _____
4. _____
5. _____

Regarding your chief complaint :

1. Have your symptoms increased or decreased since the onset ? _____

2. What has helped relieve your symptoms ? _____

3. What time of day are your symptoms most severe ? _____

4. How many days per week do you experience your symptoms ? _____

5. How has this problem affected your work, home and social life ? _____

6. What type of treatment (medical or non-medical) have you received for this problem ?

MEDICATIONS YOU ARE CURRENTLY TAKING				
	Medication	Dosage	Frequency	# of Years Used
1.				
2.				
3.				
4.				
5.				

(Continue on reverse side as necessary)

Number of courses of antibiotics taken : In last 3 yrs _____ In your life _____

VITAMINS / SUPPLEMENTS YOU ARE NOW TAKING :

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

(Continue on reverse side as necessary)

TREATMENTS, MEDICATIONS & SUPPLEMENTS used in the past which were *not* helpful:

- 1.
- 2.
- 3.

ALLERGIC REACTIONS TO :

	SYMPTOMS / REACTIONS
Drugs :	
Foods:	
Chemical / Environmental Factors :	
Animals :	

HISTORY of ILLNESSES / CONDITIONS

Please circle

Alzheimer's

Anemia

Asthma

Blood Transfusion

Cancer -

Type : _____

Chickenpox

Diabetes

Epilepsy

Heart Disease

Hepatitis

Herpes (genital)

Herpes (oral)

Herpes (shingles)

Hypertension

Kidney Disease

Mononucleosis

Pneumonia

Polio

Rheumatic Fever

Rubella (German measles)

Rubeola (Red measles)

Scarlet Fever

Sexually Transmitted Disease

Stroke

Thyroid

Tuberculosis

Whooping Cough

Other : _____

HOSPITALIZATIONS / SURGERIES

Year	Major Event	Hospital	Physician

IMMUNIZATIONS YOU'VE HAD

- | | |
|--|---|
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Polio injection (Salk) |
| <input type="checkbox"/> Diphtheria / Tetanus (TD) | <input type="checkbox"/> Pneumovax |
| <input type="checkbox"/> DPT | <input type="checkbox"/> Polio oral (Sabin) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Rubeola (Red Measles) |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Smallpox (vaccination) |
| <input type="checkbox"/> Other : _____ | |

MOST RECENT STUDIES OR TESTS

<u>TEST</u>	<u>DATE or YEAR</u>
Physical Exam	_____
Blood Chemistry / Count	_____
Cholesterol Test	_____
Urinalysis	_____
Mammogram	_____
Pap Smear	_____
X-ray	_____
CAT Scan	_____
MRI	_____
Ultrasound	_____
Colonoscopy	_____
EKG	_____
TB Test	_____
Other: _____	_____

Describe your typical exercise regime (*frequency / duration*) _____

Have you lost or gained more than 10 pounds in the last year ? _____

How much water do you drink in a day ? _____

How many times per week do you eat / drink the following

pop, soft drinks or sweetened beverages

(*Gatoraide / Sobe, etc.*) _____

sugar _____

pastries, donuts, cookies, etc. _____

candy _____

artificial sweeteners _____
(*Nutrisweet, diet pop, etc.*)

preserved meats _____
(*bacon, hotdogs, lunch meat*)

red meat _____

chicken _____

fish _____

milk _____

butter _____

eggs _____

cheese _____

yogurt _____

olive oil _____

other oil _____

margarine _____

canned foods _____

cooked vegetables _____

fast food restaurants _____

fresh vegetables _____

fresh fruit _____

garlic _____

onion _____

corn _____

soy products _____

legumes _____

bread _____

wheat _____

white flour _____

coffee _____

tea _____

Hobbies ?	
Travel ?	
Drug use ? Which drugs ?	
Alcohol consumption ?	
Tobacco Use ?	
Occupational Hazard ?	

STRESS / TRAUMA

Significant Event ? _____

What do you do to cope with stress ? _____

MENTAL / EMOTIONAL HEALTH

Poor concentration ? _____

Memory problems ? _____

Anxiety / Nervousness ? _____

Tension / Stress ? _____

Mood swings ? _____

Depression ? _____

Worrier ? _____

Cry often ? _____

Difficulty making decisions ? _____

Do you feel safe in your home ? _____



Hours of sleep per night ? _____

Trouble falling asleep ? _____

Wake in the middle of the night ? _____

Do you fall back to sleep easily ? _____

Waking rested ? _____

Chronic fatigue ? _____

Treated for emotional problems ? _____

Night Sweats ? _____

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REVIEW of SYSTEMS

Name : _____ Date: _____

Please Indicate: “C” if it is a Current problem, “P” if it is a Past problem,

BLOOD / PERIPHERAL VASCULAR

- ___ Easy bruising or bleeding
- ___ Deep leg pain
- ___ Varicose veins
- ___ Anemia
- ___ Cold hands / feet
- ___ Thrombophlebitis

BREASTS

- ___ Lumps
- ___ Nipple discharge
- ___ Pain / tenderness
- ___ Swelling
- ___ Nipple retraction
- ___ Self Exam

CARDIOVASCULAR

- ___ Heart disease
- ___ Blood clots in lungs
- ___ High Blood pressure
- ___ Chest pressure or tightness
- ___ Chest pain (Angina) or heaviness
- ___ Palpitations
- ___ Rapid heart rate at rest
- ___ Irregular heart rate
- ___ Heart murmur
- ___ Swollen ankles / feet in evening
- ___ Leg cramps when sleeping
- ___ High cholesterol or fats
- ___ Blue / Cold hands or feet
- ___ Calf pain while walking
- ___ Rheumatic Fever
- ___ Phlebitis
- ___ Fainting

EARS

- ___ Impaired Hearing
- ___ Hearing aids
- ___ Earaches

- ___ Ringing in Ears / Tinnitus
- ___ Dizziness / Vertigo
- ___ Ear discharge
- ___ Excess wax
- ___ Recurrent infections

ENDOCRINE

- ___ Thyroid problems
- ___ Hypoglycemia
- ___ Excessive thirst
- ___ Fatigue
- ___ Hair loss
- ___ Heat / cold intolerance
- ___ Diabetes
- ___ Excessive hunger
- ___ Easy weight gain

EYES

- ___ Color blindness
- ___ Glaucoma
- ___ Cataracts
- ___ Wear glasses
- ___ “See” spots / stars
- ___ Blurriness
- ___ Double vision
- ___ Tearing / dryness
- ___ Itchy eyes
- ___ Red eyes
- ___ Strain / pain
- _____ Date of last exam

GASTROINTESTINAL / DIGESTION

- ___ Weight loss / gain this year
- ___ Loss of appetite
- ___ Compulsive eater
- ___ Stomach ulcers
- ___ Heartburn
- ___ Indigestion
- ___ Food intolerances

- ___ Bloating or belching
- ___ Flatulence - gas / bloating
- ___ Nausea / Vomiting
- ___ Vomiting blood

GASTROINTESTINAL continued :

- ___ Abdominal pain
- ___ Change in stool habits
- ___ Bowel movements in night
- ___ Constipation
- ___ Straining w/ bowel movements
- ___ Diarrhea
- ___ Anti-acids / Laxatives
- ___ Black stools
- ___ Rectal pain / itching / bleeding
- ___ Hemorrhoids
- ___ Hernia (umbilical or hiatal)
- ___ Yellow skin / Liver disease
- ___ Gall stones
- ___ Pancreatitis
- ___ Colon polyps
- ___ Trouble swallowing

SKIN

- ___ Color / texture / moisture change
- ___ Sores
- ___ Itching
- ___ Severe acne
- ___ Cancer
- ___ Easy bruising / bleeding
- ___ Change in fingernails
- ___ Hair loss
- ___ Oiliness

LYMPH SYSTEM

- ___ Enlargement
- ___ Redness
- ___ Pain / tenderness

HEAD

- ___ Trauma / injury
- ___ Headache / migraines
- ___ Dizzy or light-headed
- ___ Fainting
- ___ Loss of consciousness
- ___ Feeling of spinning
- ___ Seizure disorder
- ___ Jaw / TMJ problems

IMMUNE

- ___ Chronic Fatigue
- ___ Chronically swollen glands

- ___ Reaction to vaccines
- ___ Chronic infections
- ___ Slow wound healing
- ___ Night sweats

FEMALE REPRODUCTION

- ___ Year of last PAP exam
- ___ Date of last menses
- ___ Age menses began
- ___ # of days of flow
- ___ Irregular cycles
- ___ Bleeding between cycles
- ___ Cramps
- ___ Clotting
- ___ Flow – scant / normal/ excessive
- ___ Vaginal discharge
- ___ Cervical dysplasia
- ___ Endometriosis
- ___ Ovarian cysts
- ___ Uterine fibroids
- ___ Sores on external genitalia
- ___ Infertility problems
- ___ Sexually active
- ___ Age of last menses if menopausal
- ___ Painful intercourse
- ___ Hot flashes
- ___ Vaginal dryness
- ___ Contraceptive use
- ___ # of Pregnancies
- ___ # of Live births
- ___ Breast feeding
- ___ # of Miscarriages
- ___ # of Abortions
- ___ Hysterectomy & Age
- ___ Sexually transmitted disease
- ___ Sexual concerns

MOUTH & THROAT

- ___ Trauma
- ___ Neck pain / tenderness
- ___ Thyroid problems
- ___ Sores in mouth
- ___ Bleeding / infected gums
- ___ Sore tongue / lips
- ___ Dental cavaties
- ___ Teeth grinding
- ___ Frequent sore throat
- ___ Difficulty swallowing
- ___ Hoarseness
- ___ Change in taste
- ___ Bad breath

- ___ Copious saliva
- ___ Jaw clicks

- ___ Allergies / hay fever

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MUSCULOSKELETAL

- ___ Trauma (fracture / dislocation)
- ___ Car accident
- ___ Blow to the head
- ___ Fall on buttocks
- ___ Decreased range of motion
- ___ Loss of strength
- ___ Stiff or aching muscles / joints
- ___ Neck ache / pain
- ___ Backache / pain
- ___ Arm or hand pain
- ___ Numbness / tingling
- ___ Sciatic pain – right or left
- ___ Arthritis
- ___ Swollen joints
- ___ Joint pain
- ___ Muscle spasms
- ___ Cold hands / feet

MALE REPRODUCTION

- ___ Sexually transmitted disease
- ___ Birth control
- ___ Hernias
- ___ Testicular pain
- ___ Testicular masses
- ___ Testicular self-exams
- ___ Prostate problems / enlargement
- ___ Elevated PSA
- ___ Discharge or sores
- ___ Difficulty with urination
- ___ Impotence / Sexual concerns

NOSE & SINUSES

- ___ Trauma
- ___ Sinusitis
- ___ Excess nasal drainage
- ___ Post nasal drainage (in throat)
- ___ Stuffiness / congestion
- ___ Obstruction
- ___ Nosebleed(s)
- ___ Small – loss / change
- ___ Breathe through mouth
- ___ Frequent colds
- ___ Snoring

NEUROLOGICAL

- ___ Head injury
- ___ Frequent headaches
- ___ Loss of consciousness
- ___ Fainting
- ___ Numbness- where
- ___ Tingling- where
- ___ Weakness – where ?
- ___ Tremors
- ___ Convulsions / seizures
- ___ Twitching
- ___ Difficulty walking
- ___ Speech abnormalities
- ___ Decrease / loss of sensation
- ___ Poor concentration
- ___ Loss of memory
- ___ Paralysis

RESPIRATORY

- ___ Asthma
- ___ Pneumonia
- ___ Bronchitis
- ___ Emphysema
- ___ Exposure to Tuberculosis
- ___ Pleurisy
- ___ Cough
- ___ Pain on breathing
- ___ Wheezing
- ___ Sputum – irregular
- ___ Cough up blood
- ___ Shortness of breath at rest
- ___ Shortness of breath at exertion
- ___ Hiccups

URINARY TRACT

- ___ Difficulty / inability to urinate
- ___ Pain on urination
- ___ Increased frequency
- ___ Urgency / inability to hold urine
- ___ Frequent infections
- ___ Frequency at night - # of times _____
- ___ Kidney stones
- ___ Bladder stones
- ___ Flank pain
- ___ Hernia (L or R) – inguinal or femoral

- _____ Cloudy urine
- _____ Dribbling
- _____ Bed wetting

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FAMILY HISTORY

Have any of your family members (grandparents, parents, siblings or children) had significant health issues which you would like to state here ?

RELATION

HEALTH ISSUE

ANY OTHER CONCERNS YOU WOULD LIKE TO ADDRESS ?