Progressive Chiropractic Wellness Center
Richard Ezgur, DC. 3118 N Sheffield, Suite 1s Chicago, IL 60657 tel:773-525-9355 www.progressivechiropractic.com dre@progressivechiropractic.com

## **PATIENT INFORMATION**

Name you prefer to be called (nickname):	Patient Name: Dr./Mr./Mrs./N	Иs						
Phone #:{	Name you profer to be called			Legal First				
-mail:    dodress:								
Address: City: State: Zip:     ge: Birth Date: Gender: Patient's Employer:								
Age:					State:	Zip:		
Work Address:								
Phone #: (	=			· · ·				
PERSONAL HEALTH HISTORY    Advertisement:								
Have you seen Dr. Ezgur for anything before? No/Yes, explain: Have you ever been to chiropractor before? No/Yes, what for?  Who referred you to our practice? Person: Are you, or might you be pregnant? No/Yes  What do you hope to do better or enjoy more when you regain your health?  When was your last physical exam? Results:  Oate, and results, if known, of any recent tests: cholesterol: Other:  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  Obsectibe your recreational drug use: Operative your your your your your your your your								
Have you seen Dr. Ezgur for anything before? No/Yes, explain: Have you ever been to chiropractor before? No/Yes, what for?  Who referred you to our practice? Person: Are you, or might you be pregnant? No/Yes  What do you hope to do better or enjoy more when you regain your health?  When was your last physical exam? Results:  Oate, and results, if known, of any recent tests: cholesterol: Other:  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  Obsectibe your recreational drug use: Operative your your your your your your your your								
Advertisement:  Who referred you to our practice? Person:  Are you, or might you be pregnant? No/Yes  Do you have a pacemaker? No/Yes  What do you hope to do better or enjoy more when you regain your health?  When was your last physical exam?  Results:  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):  Please list and describe all significant previous surgeries:  Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height:  Present Weight:  Weight one year ago:  Preferred Weight:		PERS	SONAL HEAI	LTH HISTORY				
Advertisement:  Who referred you to our practice? Person:  Are you, or might you be pregnant? No/Yes  Do you have a pacemaker? No/Yes  What do you hope to do better or enjoy more when you regain your health?  When was your last physical exam?  Results:  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):  Please list and describe all significant previous surgeries:  Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height:  Present Weight:  Weight one year ago:  Preferred Weight:	Have you seen Dr. Ezgur for any	thing before? No/Ye	s, explain:			_		
Who referred you to our practice? Person:								
When was your last physical exam?	Who referred you to our practice							
When was your last physical exam?	Are you, or might you be pregnar	nt? No/Yes Do you	have a pacemaker?	? No/Yes				
Date, and results, if known, of any recent tests: cholesterol:other;  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  If you smoke or have ever smoked, describe how much, and for how long:  Describe your recreational drug use:	What do you hope to do better or	r enjoy more when yo	u regain your health	?				
Date, and results, if known, of any recent tests: cholesterol:other;  Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):  If you smoke or have ever smoked, describe how much, and for how long:  Describe your recreational drug use:	When was your last physical exa			Results:				
Please list all current medications, vitamin/mineral supplements, herbs, including dosage (attach separate page if necessary):	Whom was your last physical oxa							
f you smoke or have ever smoked, describe how much, and for how long:  Describe your recreational drug use:  Typical alcohol intake (#of drinks per day/per week):  Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):  Please list and describe all significant previous surgeries:  Please list and describe all significant previous surgeries:  Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height:  Present Weight:  Weight one year ago:  Preferred Weight:	Date, and results, if known, of an	y recent tests: choles	terol:	other:				
Describe your recreational drug use:	Please list all current medications	s, vitamin/mineral sup	plements, herbs, inc	cluding dosage (attach sepa	arate page if nece	essary):		
Describe your recreational drug use:								
Describe your recreational drug use:								
Describe your recreational drug use:								
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):  Please list and describe all significant previous surgeries:  Please list and describe all significant previous surgeries:  Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height:  Present Weight:  Preferred Weight:  Preferred Weight:	If you smoke or have ever smoke	ed, describe how muc	h, and for how long:					
Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.):  Please list and describe all significant previous surgeries:  Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height:  Present Weight:  Weight one year ago:  Preferred Weight:								
Please list and describe all significant previous surgeries:  Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height: Present Weight: Weight one year ago: Preferred Weight:								
Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height: Present Weight: Weight one year ago: Preferred Weight:	Please list and describe all signif	icant previous injuries	(sprains, fractures,	accidents, etc.):				
Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height: Present Weight: Weight one year ago: Preferred Weight:								
Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:  Height: Present Weight: Weight one year ago: Preferred Weight:								
Height: Present Weight: Weight one year ago: Preferred Weight:	Please list and describe all signif	icant previous surgeri	es:					
Height: Present Weight: Weight one year ago: Preferred Weight:								
Height: Present Weight: Weight one year ago: Preferred Weight:								
Height: Present Weight: Weight one year ago: Preferred Weight:	DI III I		1 2 4 6	1 1 1 1 1 1 1 1 1				
	Please list your usual forms of ex	cercise and sports, inc	ciuaing # of times pe	er week and # of minutes pe	r session:			
	Height: Present  Any recent weight changes?:	t Weight:	Weight one y	/ear ago:	Preferred	Weight:		

## SYMPTOM LIST

Please indicate which of the symptoms listed below that you have ever experienced, with the following coding system:

- "C" if you are currently experiencing this symptom
- "R" if you tend to experience this symptom on a regular or recurring basis
- "NW" if you've never fully recovered from (never been completely well since having this symptom)
- "P" if you've experienced this symptom in the past

Frequent or recurring Chills   Endwesting   Epilosys/Corvulsions/Solzure   Frequent or recurring Disziness   Uninary tract infections   Kidney stones   Spitting up blood   Spitting up blood   Prequent or recurring Fating   Frequent or recurring Fating   Frequent or recurring Fating   Painful unination   Irregular menstrual cycle   Officult breathing   Frequent or recurring Fating   Painful unination   Hot flashes   Ashma   A	<u>GENERAL</u>	GENITO-URINARY/EN	<u>IDOCRINE</u>	RESPIRATORY
Frequent or recurring Dizziness Frequent or recurring Faligue Frequent or recurring Sieep loss Recent Weight Change Anview/Frainc Attacks Depression Depression Depression Depression Perquent or recurring Newstashes Depression Frequent or recurring Newstashes Frequent or recurring Newstashes Depression Frequent or recurring Newstashes Depression Frequent or recurring Newstashes Depression Frequent Newstashes Depression Depression Frequent Newstashes Depression Depressi		Bedwetting	Blood in urine	Spitting up phlegm
Frequent or recurring Failuting Frequent or recurring Silese loss Frequent or recurring Silese ploss Frequent or recurring Silese ploss Frequent or recurring Silese ploss Frequent for Recurring Failuting Anxiety/Panic Attacks Depression Frequent or recurring Sweats Frequent/recurring Newstrashes Frequent/recurring colds/filuting Frequent/recurring Frequent/recurring Frequent/recurring Frequent/recurring Frequent/recurring Frequent/recurring Frequent/recurr				
Frequent or recurring Failgue Forstate trouble Diabetes Control Felvic Inflam, Dis. Chronic cough Headache Loss of bowelbladder control Infertility/Miscarriage Gall Stones Infertility/Miscarriage Aneity/Panic Atlacks Boloting, Bebloting, gas Diabetes Diarrhea High blood pressure Frequent or recurring Sweats Frequent recurring hives/rashes Frequent/recurring hives/rashes Frequent/recurring hives/rashes Frequent/recurring hives/rashes Frequent/recurring hives/rashes Frequent/recurring hives/rashes Frequent/recurring colds/flu Ulcer Poor appetite Rapid heart beat Diagnostive Problems Candida/Yeast Heart Disease Fears/Phobias Parasites Hernia Palation/freq heart beat Cold Hands &/or Feet Pears/Phobias Pears/Phobias Dealness Neck Amm: R/L both Absesses Neck Ebows: R/L both Alcoho/Drug Addiction Mid Back Amm: R/L both Alcoho/Drug Addiction Mid Back Amm: R/L both Alcoho/Drug Addiction Mid Back Amm: R/L both Alcoho/Drug Addiction Almens Sinus problems Between Shoulder Blades Hip; R/L both Anemia Canker sores Froquent/recurring nose bleeds Shoulder Blades Hip; R/L both Anemia Canker Sorose Fibronyalgia Arthris-Gout Genial Warts Mononucleosis Programmida Disease Saudal Abuse Struck British Amms Amms Mononucleosis Dealness Saudal Abuse Struck British Amms Mononucleosis Saudal Abuse Struck British Amms		Urinary tract infections		
Frequent or recurring Fever   Prostate trouble   Diabetes   Mezing   Chronic cough   Frequent or recurring Steep loss   Gall Stones   Infertility/Miscarriage   CASTROINTESTINAL   CARDIOVASCULAR   Altering of arteries   CASTROINTESTINAL   CARDIOVASCULAR   CARDIOVASCULAR   CARDIOVASCULAR   CARDIOVASCULAR   CARDIOVASCULAR   CARDIOVASCULAR   CARDIOVASCULAR   Hardening of arteries   Esophageal reflux   Diarrhea   Hardening of arteries   Constitution   Vorniting   Pain over heart   Prequent hearthurn   Nausea   Bad circulation/ankle swe   Frequent/recurring heves/rashes   Frequent/recurring podes/flu   Vertigo   Digestive Problems   Candida/Yeast   Heart Disease   Painting   Parasites   Hernia   Painting   Painting   Painting   Parasites   Problems   Candida/Yeast   Heart Disease   Painting   Parasites   Painting   Pa		Painful urination		Difficult breathing
Headache   Loss of bowel/bladder control   Pelvic Inflam. Dis.   Chronic cough   Frequent or recurring Sleep loss   Recent Weight Change   Gall Stones   Pain over stomach   Hardening of arteries   High blood pressure   Hardening of arteries   High blood pressure		Painful menstruation	Hot flashes	
Recent Weight Change Anxiety/Panic Attacks Dopression Frequent or recurring Sweats Frequent or recurring Sweats Frequent frecurring colds/flu Vertigo Fainting Fears/Phobias FYES, EARS, NOSE, THROAT Frequent/recurring sore throat Dearlies Dentification/faniles Frequent/recurring sore throat Dearlies Frequent/recurring sore throat Dearlies Frequent/recurring colds/flu Vertigo Fainting Fears/Phobias FYES, EARS, NOSE, THROAT Frequent/recurring sore throat Deafness Deafness Dental problems Uniform Sweats Deafness Dental problems Deafness Dental problems Deafness Sinus problems Sinus problems Sinus problems Sinus problems Candidaryeast Low Back Elbow: RIL both Ance Between Shoulder Blade: RIL both Frequent/recurring nose bleeds Vision problems Jishoulder RIL both Frequent/recurring nose bleeds Vision problems Canker sores Cold sores Cold sores Foot: RIL bunions/corms Cold sores Fibromyalgia Deafness Portier OTHER OTHER OTHER Warts OTHER OTHER OTHER OTHER Warts Mononucloosis Genital Herpes Mumps Mononucloosis Position Po		Prostate trouble		
Rocent Weight Change Anxiety/Panic Attacks Anxiety/Panic Attacks Depression Depression Esophageal reflux Diarrhea Frequent or recurring Sweats Frequent/recurring hives/rashes Frequent/recurring hives/rashes Frequent/recurring colds/flu Ulcer Vertigo Vertigo Vertigo Parisites Frequent/recurring colds/flu Ulcer Vertigo Digastive Problems Fainting Parisites Frequent/recurring sore throat Deathess Frequent/recurring sore throat Deathess Upper Back Hand: Rt. both Absesses Dental problems Behveren Shoulder Blades Figurent/recurring nose bleeds Shoulder Rt. both Shoulder Rt. both Anneria Sinus problems Behveren Shoulder Rt. both Vision problems Shoulder Rt. both Vision problems Shoulder Rt. both Ankle: Rt. both Cancer Cancer Cold sores Fibornyalgia Anthritis/Gout Genital Warts OTHER OT				
Anxiety/Panic Attacks   Bloating, belching, gas   Pain over stomach   Hardening of arteries	Frequent or recurring Sleep loss	Gall Stones		
Anxiety/Panic Attacks Depression Depression Esophageal reflux Diarrhea Frequent or recurring Sweats Frequent/recurring hives/rashes Frequent/recurring colds/flu Vertigo Vertigo Frieduent/recurring colds/flu Vertigo Frieduent/recurring sore throat Deafness Dental problems Dental problem	Recent Weight Change	GASTROINTESTIN	<u>IAL</u>	CARDIOVASCULAR PROPERTY OF THE
Depression	Anxiety/Panic Attacks	Bloating, belching, gas	Pain over stomach	Hardening of arteries
Frequent/recurring hives/rashes Frequent/recurring colds/flu Vertigo Vertigo Vertigo Fainting Fainting Fainting Fainting Fainting Farsites Frequent/recurring sore throat Deafhess Deafhess Deafhess Deafhess Deafhess Dental problems Differ Richering Sinus problems Frequent/recurring sore throat Deafhess Dental problems	Depression	Esophageal reflux	Diarrhea	High blood pressure
Frequent/recurring colds/flu   Ulcer   Poor appetite   Rapid heart beat   Vertigo   Digestive Problems   Candida/Yeast   Heart Disease   Fainting   Parasites   Heart Disease   Palpitation/trog heart beat   Cold Hands &/or Feet	Frequent or recurring Sweats	Constipation	Vomiting	Pain over heart
Vertigo Digestive Problems Candida/Yeast Heart Diseases Paintition/fireg heart beat Cold Hands &/or Feet EYES, EARS, NOSE, THROAT  FERSE, EARS, NOSE, THROAT  Frequent/recurring sore throat Dentes Nose Cold Hands &/or Feet Dentes Cold Hands &/or Feet Dent		Frequent heartburn		Bad circulation/ankle swel
Fainting Fears/Phobias			Poor appetite	Rapid heart beat
Fears/Phobias   FYES_EARS, NOSE_THROAT   Low Back		Digestive Problems	Candida/Yeast	
Section   Sect		Parasites	Hernia	
Frequent/recurring sore throat   Low Back   Arm: R/L both   Aone	Fears/Phobias		<u>-</u>	
Deatness Neck Elbow: R/L both Acne Dental problems Upper Back Hand: R/L both Alcohol/Drug Addiction Ear problems/Infections Mid Back Leg: R/L both Anemia Sinus problems Sinus problems Sinus problems Shoulder Blades Hip: R/L both Anemia Sinus problems Shoulder Blades R/L both Anemia Sinus problems Shoulder Blades R/L both Anemia Athete's Foot/Fungal infectio Vision problems Shoulder Blades R/L both Anemia Athete's Foot/Fungal infectio Canker sores Shoulder: R/L both Ankie: R/L both Chicken Pox Canker sores Cold sores Fibromyalgia Arthritis/Gout Genital Warts OTHER OTHER Warts Mononucleosis Genital Herpes Mumps Hepatitis Psoriasis Pnuemonia Root Canal/gumdisease Scarlet Fever Sexually Transmitted Disease Sexual Abuse Stroke HIV Whooping Cough Worms Ungrown Toenalis/Hang-nails Teeth Problems/Cavities Penier/Vaginal Discharge Dry/Cracked heels  Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1. 2. 3. 4. 5. 6. 7. 8. 9. 10. Pelease list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom: Family members also affected:	EYES, EARS, NOSE, THROAT	MUSCULOSKELETAL - pain, nu	umbness, weakness in:	OTHER
Deatness Neck Elbow: R/L both Acne Dental problems Upper Back Hand: R/L both Alcohol/Drug Addiction Ear problems/Infections Mid Back Leg: R/L both Anemia Sinus problems Sinus problems Sinus problems Shoulder Blades Hip: R/L both Anemia Sinus problems Shoulder Blades R/L both Anemia Sinus problems Shoulder Blades R/L both Anemia Athete's Foot/Fungal infectio Vision problems Shoulder Blades R/L both Anemia Athete's Foot/Fungal infectio Canker sores Shoulder: R/L both Ankie: R/L both Chicken Pox Canker sores Cold sores Fibromyalgia Arthritis/Gout Genital Warts OTHER OTHER Warts Mononucleosis Genital Herpes Mumps Hepatitis Psoriasis Pnuemonia Root Canal/gumdisease Scarlet Fever Sexually Transmitted Disease Sexual Abuse Stroke HIV Whooping Cough Worms Ungrown Toenalis/Hang-nails Teeth Problems/Cavities Penier/Vaginal Discharge Dry/Cracked heels  Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1. 2. 3. 4. 5. 6. 7. 8. 9. 10. Pelease list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom: Family members also affected:	Frequent/recurring sore throat	Low Back	Arm: R/L both	Absesses
Ear problems/Infections		Neck	Elbow: R/L both	Acne
Ear problems/Infections	Dental problems	Upper Back	Hand: R/L both	Alcohol/Drug Addiction
Sinus problems   Between Shoulder Blades   Hip: R/L both   Athlete's Foot/Fungal infectio   Frequent/recurring nose bleeds   Shoulder Blades   R/L both   Knees   K.L both   Cancer   Vision problems   Shoulder: R/L both   Ankle: R/L both   Chicken Pox   Canker sores   Foot: R/L both   Ankle: R/L both   Chicken Pox   Canker sores   Foot: R/L both   Ankle: R/L both   Chicken Pox   Canker sores   Foot: R/L both   Ankle: R/L both   Chicken Pox   Canker sores   Foot: R/L both   Ankle: R/L both   Chicken Pox   Canker sores   Foot: R/L both   Ankle: R/L both   Chicken Pox   Canker sores   Foot: R/L both   Ankle: R/L both   Chicken Pox   Spinal curvature   Eczema   Cold sores   Fibromyalgia   Arthritis/Gout   Genital Warts   Mononucleosis   Genital Herpes   Mumps   Hepatitis   Psoriasis   Phuemonia   Root Canal/gumdisease   Scarlet Fever   Reversally Transmitted Disease   Sexual Abuse   Stroke   HIV   Whooping Cough   Worms   Stroke   HIV   Whooping Cough   Worms   Teeth Problems/Cavities   Penile/Vaginal Discharge   Dry/Cracked heels   Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.   1.	Ear problems/Infections		Leg: R/L both	
Frequent/recurring nose bleeds Vision problems Shoulder: R/L both Vision problems Shoulder: R/L both Chicken Pox Canker sores Foot: R/L bunions/coms Spinal curvature Eczema Cold sores Fibromyalgia Arthritis/Gout Genital Warts  OTHER OTHER OTHER Murps Hepatitis Psoriasis Pnuemonia Root Canal/gumdisease Scarlet Fever Sexuall Abuse Whooping Cough Worms Shingles Chicken Pox Ingrown Toenails/Hang-nalls Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1. 2. 3. 4. 5. 6. 7. 8. 9. 10.  Please list any other symptoms that were not listed above: Family members also affected: Symptom: Family members also affected:		Between Shoulder Blades		Athlete'sFoot/Fungal infection
Canker sories   Foot: R/L bunions/coms   Spinal curvature   Eczema   Cold sories   Fibromyalgia   Arthritis/Gout   Genital Warts   Mononucleosis   Genital Herpes   Mumps   Hepatitis   Psoriasis   Pnuemonia   Root Canal/gundisease   Scarlet Fever   Sexually Transmitted Disease   Sexual Abuse   Stroke   HIV   Whooping Cough   Worms   Shingles   Chicken Pox   Ingrown Toenalis/Hang-nails   Teeth Problems/Cavities   Penile/Vaginal Discharge   Dry/Cracked heels    Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1.   2.   3.   4.   5.   6.   7.   8.   9.   10.   Please list any other symptoms that were not listed above:    Please list any other symptoms that were not listed above:    Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:   Symptom:   Family members also affected:	Frequent/recurring nose bleeds	Shoulder Blade: R/L both	Knee: R/L both	
Cold sores   Fibromyalgia   Arthritis/Cout   Genital Warts   OTHER   OTHER   Warts   Warts	Vision problems	Shoulder: R/L both	Ankle: R/L both	Chicken Pox
OTHER         OTHER         OTHER         Warts           Mononucleosis         Genital Herpes         Mumps         Hepatitis           Psoriasis         Pnuemonia         Root Canal/gumdisease         Scarlet Fever           Sexually Transmitted Disease         Sexuall Abuse         Stroke         HIV           Whooping Cough         Worms         Shingles         Chicken Pox           Ingrown Toenails/Hang-nails         Teeth Problems/Cavities         Penile/Vaginal Discharge         Dry/Cracked heels           Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.           1.         2.           3.         4,           5.         6.           7.         8.           9.         10.           Please list any other symptoms that were not listed above:    Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Family members also affected:  Family m	Canker sores	Foot: R/L bunions/corns	Spinal curvature	Eczema
Mononucleosis	Cold sores	Fibromyalgia	Arthritis/Gout	Genital Warts
Psoriasis Pnuemonia Root Canal/gumdisease Scarlet Fever Sexually Transmitted Disease Sexual Abuse Stroke HIV Whooping Cough Worms Shingles Chicken Pox Ingrown Toenails/Hang-nails Teeth Problems/Cavities Peniler/Vaginal Discharge Dry/Cracked heels  Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom: Family members also affected:	OTHER	OTHER	OTHER	Warts
Psoriasis Pnuemonia Root Canal/gumdisease Scarlet Fever Sexually Transmitted Disease Sexual Abuse Stroke HIV Whooping Cough Worms Shingles Chicken Pox Ingrown Toenails/Hang-nails Teeth Problems/Cavities Peniler/Vaginal Discharge Dry/Cracked heels  Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom: Family members also affected:	Mononucleosis	Genital Herpes	Mumps	Hepatitis
Sexually Transmitted Disease Sexual Abuse Stroke HIV Whooping Cough Worms Shingles Chicken Pox Ingrown Toenalis/Hang-nails Teeth Problems/Cavities Penile/Vaginal Discharge Dry/Cracked heels  Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1. 2. 3. 4. 5. 6. 7. 8. 9. 10. Please list any other symptoms that were not listed above:  Please list any other symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom: Family members also affected:				
Whooping Cough	Sexually Transmitted Disease	Sexual Abuse		HIV
Ingrown Toenails/Hang-nails Teeth Problems/CavitiesPenile/Vaginal Discharge Dry/Cracked heels  Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1		Worms	Shingles	Chicken Pox
Finally, from the symptoms listed above, rank your most important 5-10 symptoms below, in terms of their priority, with 1 being the most important.  1	Ingrown Toenails/Hang-nails	Teeth Problems/Cavities	Penile/Vaginal Discharge	Dry/Cracked heels
4. 5. 6. 7. 8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Family members also affected:	most important.  1	ve, rank your most important 5-10 s	ymptoms below, in terms of	their priority, with 1 being the
5. 6. 7. 8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:				
6. 7. 8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:				
7. 8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:				
8. 9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:				_
9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:  Family members also affected:	7.			
9. 10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:  Family members also affected:	8.			
10.  Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:				
Please list any other symptoms that were not listed above:  Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:				
Of ALL the symptoms listed above, please indicate which of these also exist, or have existed, in any of your family members:  Symptom:  Symptom:  Family members also affected:  Family members also affected:  Symptom:  Family members also affected:  Family members also affected:				
Symptom: Family members also affected: Family members also affected: Symptom: Family members also affected: Family members also a	Please list any other symptoms that w	ere not listed above:		
Symptom: Family members also affected: Family members also affected: Symptom: Family members also affected: Family members also a	Of ALL the symptoms listed above, pl	lease indicate which of these also ex	xist, or have existed, in any	of your family members:
Symptom: Family members also affected: Symptom: Family members also affected:	Symptom:	Family members a	also affected:	
Symptom: Family members also affected:	Symptom:	Family members a	also affected:	
	Symptom:	Family members a	also affected:	
Please list any other significant health problems of parents, grandparents, or siblings:	Symptom:	Family members a	also affected:	
	Please list any other significant health	problems of parents, grandparents	, or siblings:	

## SPOUSE/PARTNER/FAMILY MEMBERS' OBSERVATIONS

If possible, it would be helpful to get any additional insight from your spouse, or other family members. Of importance are things difficult for one to observe of him or herself. This includes sleep behavior (snoring, talking, crying out during dreams, movements/positions, uncovering). Also useful are childhood behaviors, fears, traumas (physical or emotional), which might be remembered by a parent or older sibling.

eep behavior:
nildhood fears, behavior, trauma:
y other observations:
NUTRITION
hich do you eat on a typical day: { }Breakfast { }Lunch { }Dinner # of snacks/day:
ease indicate the estimated number of servings of each of the following, which you eat on a typical day:  Eggs Red Meat Fruits Yogurt Tofu/Soy Fish Cheese Spicy Foods Vegetables Grains, Rice, Pasta, Cereal, Bread Milk Bacon/Hot Dogs Desserts Chicken/Turkey Margarine Nuts/Seeds/Peanut Butter Sausage/Lunch Meats Regular Soft Drinks Water Regular Cofffee Decaf. Coffee Diet Soft Drinks Fruit Juices Regular Tea Decaf. Tea Herbal Tea Sports Drinks (i.e., Gatorade)
a scale of 1-10, (10 being perfectly healthy) how healthy would you rate your diet:
ou try to follow a special diet (i.e., low fat, low cholesterol, low calorie, low sodium, low carb, diabetic), please describe: