WELCOME BACK

Name:	Who are you seeing today?	Birth Date: / /	Today's Date: / /

DO YOU HAVE ANY SPECIFIC GOALS FOR TODAY'S VISIT? ARE THERE ANY CHANGES TO YOUR CURRENT CONDITION? ANY NEW COMPLAINTS?

HAVE THERE BEEN ANY CHANGES TO YOUR SUPPLEMENTS/MEDICATIONS: (PLEASE LIST DOSE AND BRAND IF POSSIBLE)

ANY CHANGES TO INSURANCE OR PREFERRED PHARMACY?

Please tell us about any symptoms you've been having **since your last visit**.

GENERAL:	☐ NO COMPLAINTS	☐ WEIGHT LOSS	☐ FATIGUE	☐ COLD/FLU	☐ HARDER TIME EXERCISING
	☐ STRESS	☐ WEIGHT GAIN	☐ INSOMNIA	☐ CHANGES IN STRENGTH	☐ OTHER _____
HEAD/EAR:	☐ NO COMPLAINTS	☐ DIZZINESS	☐ HEADACHES	☐ HEAD TRAUMA	☐ MENTAL FOG
	☐ EARACHE	☐ CHANGES IN HEARING	☐ RINGING IN EARS	☐ CLOGGED EARS	☐ OTHER _____
EYES:	☐ NO COMPLAINTS	☐ CHANGES IN VISION	☐ BLURRING OF VISION	☐ EXCESSIVE TEARING	☐ OTHER _____
	☐ BLIND SPOTS	☐ EYE PAIN	☐ EYE IRRITATION	☐ DRY EYES	
NOSE/MOUTH:	☐ NO COMPLAINTS	☐ FREQUENT BLEEDING	☐ BLEEDING GUMS	☐ COLD/CANKER SORES	☐ TOOTH PAIN
	☐ BAD BREATH	☐ NASAL DISCHARGE	☐ NASAL CONGESTION	☐ DRY MOUTH/NOSE	☐ OTHER _____
NECK/THROAT:	☐ NO COMPLAINTS	☐ NECK PAIN/STIFFNESS	☐ LUMPS/BUMPS	☐ POSTNASAL DRIP	☐ OTHER _____
	☐ SORE THROAT	☐ DIFFICULTY SWALLOWING			
CHEST/LUNG /BREAST:	☐ NO COMPLAINTS	☐ BREAST TENDERNESS	☐ PAIN W/ BREATHING	☐ CHEST CONSTRICTION	☐ SHORT OF BREATH/WHEEZING
	☐ LUMPS/SWELLING	☐ NIPPLE DISCHARGE	☐ COUGH	☐ CHEST CONGESTION	☐ OTHER _____
CARDIOVASCULAR:	☐ NO COMPLAINTS	☐ PALPITATIONS	☐ CHEST PAIN	☐ HIGH BLOOD PRESSURE	☐ OTHER _____
		☐ IRREGULAR BEAT	☐ LEG SWELLING	☐ LOW BLOOD PRESSURE	☐ LOSS OF CONSCIOUSNESS
ABDOMEN/DIGESTION:	☐ NO COMPLAINTS	☐ ABDOMINAL PAIN	☐ DIARRHEA	☐ HEART BURN	☐ BLOATING/GAS
BOWEL MOVEMENTS PER DAY_____	☐ NAUSEA/VOMITING	☐ CHANGE IN APPETITE	☐ CONSTIPATION	☐ BLOOD IN STOOL	☐ OTHER _____
URINATION:	☐ NO COMPLAINTS	☐ FREQUENCY	☐ URGENCY	☐ FREQUENT INFECTIONS	
	☐ PAINFUL URINATION	☐ INCONTINENCE	☐ DRIBBLING	☐ INCOMPLETE EMPTYING	☐ OTHER _____
WOMENS HEALTH:	☐ NO COMPLAINTS	☐ PAIN WITH MENSES	☐ PELVIC PAIN	☐ DIFFICULTY CONCEIVING	☐ CYCLE LENGTH: _____DAYS
DAY #_____ IN CYCLE	☐ CHANGE IN MENSES	☐ VAGINAL DISCHARGE	☐ SPOTTING	☐ MENOPAUSE/NO PERIOD	☐ OTHER _____
MENS HEALTH:	☐ NO COMPLAINTS	☐ ERECTILE DYSFUNC.	☐ NIGHTIME URINATION	☐ OTHER _____	
	☐ DECREASED LIBIDO	☐ PROSTATE	☐ ____TIMES PER NIGHT		
MUSCULOSKELETAL:	☐ NO COMPLAINTS	☐ MUSCLE PAIN	☐ MUSCLE TENSION	☐ NUMBNESS/TINGLING	☐ RECENT INJURY
	☐ MUSCLE CRAMPS	☐ MUSCLE WEAKNESS	☐ JOINT PAIN	☐ RANGE OF MOTION	☐ OTHER _____
MENTAL/EMOTIONAL:	☐ NO COMPLAINTS	☐ SEIZURES	☐ MOOD CHANGES	☐ DEPRESSION	☐ LOSS OF COORDINATION
	☐ MEMORY CHANGES	☐ TREMOR	☐ MENTAL CHANGES	☐ COGNITIVE IMPAIRMENT	☐ OTHER _____
TEMPERATURE:	☐ NO COMPLAINTS	☐ RUNS COLD	☐ NIGHT SWEATING	☐ EXCESS SWEATING	☐ OTHER _____
	☐ COLD HAND/FEET	☐ RUNS HOT	☐ HOT FLASHES	☐ LACK OF SWEATING	☐ SPONTANEOUS SWEATING
SKIN/HAIR:	☐ NO COMPLAINTS	☐ EASY BRUISING	☐ RASH	☐ TEXTURE CHANGES	☐ CHANGES IN NAILS
	☐ DRYNESS	☐ SLOW HEALING	☐ COLOR CHANGES	☐ THINNING HAIR	☐ OTHER _____