HUDSON VALLEY
WHOLE LIFE CENTER

Patient Name:_____ **Patient Date of Birth:**____/____/____

Past Medical History

Please include any of your previous conditions.
If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas ☐No ☐Yes Explain:
Illnesses/Hospitalizations: ☐No ☐Yes Explain:
Surgeries: ☐No ☐Yes Explain:

Motor Vehicle Accidents ☐No ☐Yes Explain:
Work Injuries ☐No ☐Yes Explain:

Females Only: Menopausal Symptoms ☐None ☐Yes Explain:

Habits

Cigarettes/Cigars	☐None ☐Yes How much per week?
Alcohol	☐None ☐Yes How many drinks per week?
Coffee	☐None ☐Yes How many cups per week?
Exercise	☐None ☐Yes Hours/days per week?
Water	☐None ☐Yes How many glasses per week?
Soft Drinks	☐None ☐Yes Amount per week?
Sleep	☐None ☐Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? ☐No ☐Yes Explain:

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

☐Diabetes ☐Heart Disease ☐Stroke ☐Neurological Disorders_____
☐Autoimmune Disorders_____ ☐Cancer_____
☐Other_____

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Personal Health History

Medications: Please list your current medications and what they are taken for,
Vitamins and Minerals: Please list your current supplements and by who prescribed.

Check the left box for any condition YOU had in the PAST and the right box for any condition this is CURRENT.

General Health History

P C	P C	P C	P C
☐ ☐ Mental Disorders	☐ ☐ Diabetes	☐ ☐ Pneumonia	☐ ☐ Infective Disease
☐ ☐ Epilepsy	☐ ☐ Anemia	☐ ☐ Tuberculosis	☐ ☐ Fungal Infection
☐ ☐ Tumors	☐ ☐ Glaucoma	☐ ☐ Hepatitis	☐ ☐ Herpes
☐ ☐ Alcoholism	☐ ☐ Heart Disease	☐ ☐ Thyroid Disease	☐ ☐ Arthritis
☐ ☐ Drug Addiction	☐ ☐ Rheumatic Fever	☐ ☐ Parasites	☐ ☐ Autoimmune Disease
☐ ☐ Cancer	☐ ☐ Scarlet Fever	☐ ☐ Asthma	☐ ☐ Chicken Pox

Nervous System	**Eyes/Ears/Nose/Throat**	**Gastrointestinal**	☐ ☐ Venereal Infection
P C	**P C**	**P C**	**Musculoskeletal**
☐ ☐ Depression	☐ ☐ Vision Problems	☐ ☐ Poor/Excess Appetite	**P C**
☐ ☐ Memory	☐ ☐ Flashing Lights	☐ ☐ Excessive Thirst	☐ ☐ Jaw Pain
☐ ☐ Confusion	☐ ☐ Black Spots	☐ ☐ Frequent Nausea	☐ ☐ Difficulty Chewing
☐ ☐ Dizziness	☐ ☐ Blurriness	☐ ☐ Hemorrhoids	☐ ☐ Face Pain
☐ ☐ Fainting	☐ ☐ Hearing Loss	☐ ☐ Black/Bloody Stools	☐ ☐ Neck Pain
☐ ☐ Convulsions	☐ ☐ Ringing in Ears	☐ ☐ Digestive Problems	☐ ☐ Arm/Elbow Pain
☐ ☐ Weakness	☐ ☐ Swallowing Difficulty	☐ ☐ Abdominal Cramping	☐ ☐ Wrist/Hand Pain
☐ ☐ Poor Balance	**Cardiovascular**	☐ ☐ Gas/Bloating	☐ ☐ Mid Back Pain
☐ ☐ Twitches/Tremor	☐ ☐ Chest Pain	☐ ☐ Heartburn	☐ ☐ Lower Back Pain
☐ ☐ Cold/Tingle Extremities	☐ ☐ Irregular Heartbeat	☐ ☐ Weight Problems	☐ ☐ Thigh/Knee Pain
☐ ☐ Sleeping Difficulties	☐ ☐ High Blood Pressure	☐ ☐ Gall Bladder Problems	☐ ☐ Ankle/Foot Pain
☐ ☐ Headaches	☐ ☐ Shortness of Breath	☐ ☐ Liver Problems	☐ ☐ Difficulty Walking
Genitourinary	☐ ☐ Lung/Congestion Prob.	**Reproductive**	☐ ☐ Leg/Arm Fatigue
☐ ☐ Bladder Trouble	☐ ☐ Varicose Veins	☐ ☐ Erectile Difficulties	
☐ ☐ Painful Urination	☐ ☐ Ankle Swelling	☐ ☐ Sexual Dysfunction	
☐ ☐ Incontinence		☐ ☐ Menstrual Irregularity	
☐ ☐ Discolored Urine		☐ ☐ Menstrual Cramping	

Females Only: When did your menses first begin?	
How often do you have a bowel movement?	How many times per day do you urinate?
Do your stools ☐Float or ☐Sink?	Do you experience any urgency, dribbling, or incontinence?
Are your bowel movements consistent?	Is this urination pattern consistent? ☐Yes ☐No

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Please list your major complaints in order of severity (from most debilitating to least debilitating):

1.	4.
2.	5.
3.	6.

Complaint #1- _____

When did you first notice this condition?
Did it begin: ☐Immediate or ☐Gradually? Briefly describe
What is the exact location of your symptoms:
Do your symptoms spread? ☐No ☐Yes Where?
How often do you experience these symptoms? ☐Constant (100% of the day) ☐Frequent ☐Often (50%) ☐Seldom (25%) ☐Rarely (less than 25%)
Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged
What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is your pain ☐Deep or ☐Superficial
Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching If yes, please describe:
Please indicate what activities Provoke(P) or Aggravate(A) your condition: ☐Sitting__min. ☐Standing ☐Walking ☐Lying ☐Pushing ☐Lifting ___lbs. ☐Gripping ☐Hot/Cold ☐Coughing/sneezing ☐Bowel Movements ☐Mental activities ☐Bright lights ☐Other_____ ☐Other_____ ☐Other_____ ☐Other_____
Please indicate what helps to alleviate the pain: ☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____ ☐_____ ☐_____ ☐_____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this complaint.

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Complaint #2-_____

When did you first notice this condition?
Did it begin: ☐Immediate or ☐Gradually? Briefly describe
What is the exact location of your symptoms:
Do your symptoms spread? ☐No ☐Yes Where?
How often do you experience these symptoms? ☐Constant (100% of the day) ☐Frequent ☐Often (50%) ☐Seldom (25%) ☐Rarely (less than 25%)
Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged
What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is your pain ☐Deep or ☐Superficial
Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching If yes, please describe:
Please indicate what activities Provoke(P) or Aggravate(A) your condition: ☐Sitting__min. ☐Standing ☐Walking ☐Lying ☐Pushing ☐Lifting ___lbs. ☐Gripping ☐Hot/Cold ☐Coughing/sneezing ☐Bowel Movements ☐Mental activities ☐Bright lights ☐Other_____ ☐Other_____ ☐Other_____ ☐Other_____
Please indicate what helps to alleviate the pain: ☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____ ☐_____ ☐_____ ☐_____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this complaint.

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Patient Name:_____ **Patient Date of Birth:**____/____/____

Complaint #3-_____

When did you first notice this condition?
Did it begin: ☐Immediate or ☐Gradually? Briefly describe
What is the exact location of your symptoms:
Do your symptoms spread? ☐No ☐Yes Where?
How often do you experience these symptoms? ☐Constant (100% of the day) ☐Frequent ☐Often (50%) ☐Seldom (25%) ☐Rarely (less than 25%)
Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged
What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is your pain ☐Deep or ☐Superficial
Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching If yes, please describe:
Please indicate what activities Provoke(P) or Aggravate(A) your condition: ☐Sitting__min. ☐Standing ☐Walking ☐Lying ☐Pushing ☐Lifting ___lbs. ☐Gripping ☐Hot/Cold ☐Coughing/sneezing ☐Bowel Movements ☐Mental activities ☐Bright lights ☐Other_____ ☐Other_____ ☐Other_____ ☐Other_____
Please indicate what helps to alleviate the pain: ☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____ ☐_____ ☐_____ ☐_____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this complaint.

IF YOU HAVE MORE THAN 3 COMPLAINTS, PLEASE ASK THE RECEPTIONIST FOR ADDITIONAL "COMPLAINT" DESCRIPTION FORMS.

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Patient Name:_____ **Patient Date of Birth**:____/____/____

Complaint #___-_____

When did you first notice this condition?
Did it begin: ☐Immediate or ☐Gradually? Briefly describe
What is the exact location of your symptoms:
Do your symptoms spread? ☐No ☐Yes Where?
How often do you experience these symptoms? ☐Constant (100% of the day) ☐Frequent ☐Often (50%) ☐Seldom (25%) ☐Rarely (less than 25%)
Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged
What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is your pain ☐Deep or ☐Superficial
Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching If yes, please describe:
Please indicate what activities Provoke(P) or Aggravate(A) your condition: ☐Sitting__min. ☐Standing ☐Walking ☐Lying ☐Pushing ☐Lifting ___lbs. ☐Gripping ☐Hot/Cold ☐Coughing/sneezing ☐Bowel Movements ☐Mental activities ☐Bright lights ☐Other_____ ☐Other_____ ☐Other_____ ☐Other_____
Please indicate what helps to alleviate the pain: ☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____ ☐_____ ☐_____ ☐_____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this complaint.