Windhorse Medicine

512.917.3404
1210 Rosewood Avenue, Austin, Tx, 78702
www.windhorsemedicine.com

Full Name	Age DOB / / Sex: F / M
Best Way to Contact You? Email / Phone / Mail Mailing Address: Email:	Phone Type Good Time(s) *(555) 555 - 5555 Cell* AM/Noon/PM (_____) _____-__________ ___________ AM/Noon/PM (_____) _____-__________ ___________ AM/Noon/PM (_____) _____-__________ ___________ AM/Noon/PM
In Emergency Notify	Relationship
Marital Status	SS#

How did you hear about our office? ________________________

Please Initial hear to give us permission to thank the person who referred you_______________

You would like help with:	What kind(s) of treatment have you tried?
When did this problem begin? What led up to this problem?	What makes it worse? What makes it better?
To what extent does this interfere with your daily activities? (work, sleep, sex, etc.)	Is there anything else you feel I should know?

Past medical history (please indicate mo/yr of diagnosis) Cancer Diabetes Hepatitis Thyroid Disease Seizures Breathing Problems Heart Disease Digestive Disorders HIV/AIDS Positive Venereal Disease	Surgeries: Hospitalization: Signifigant Trauma (auto accidents, sports injuries, etc.)
Family medical history (please specify family member) Cancer Diabetes Hepatitis Hypertension Stroke Heart Disease Asthma Alcoholism Miscarriage Other (please specify)	Allergies: (seasonal, drugs, chemicals, foods, etc.) Medicines, Vitamins and Herbs taken within the last two months:

Personal Tastes	Favorite flavor of food ______________	Please rate on a scale of
Favoite time of year ______________	Predominate Emotion ______________	1 (lowest) to 10 (highest)
Favorite time of day ______________	Do you enjoy your job? ______________	Energy Level ________ Mood __________

Do you work indoors / outdoors? How many hours/week? __________ Occupational Stress __________ (chemical, physical,etc)

Diet

How much coffee do you drink? __________cups/day

Colas __________number/day Tea __________cups/day

Alcoholic beverages: __________drinks/week

Are you a vegetarian? Y / N / Yes but not strict

Do you eat a lot of sugary foods? Y / N

Do you eat a lot of fast foods? Y / N

Do you eat a lot of processed foods? Y / N

Do you eat a lot of spicy foods? Y / N

Do you eat a lot of greasy oil foods? Y / N

Please describe you average daily diet:

Morning:

Afternoon:

Evening:

Snacks

Height __________ Weight __________ One year ago__________ Weight Maximum __________when(year)__________

Do you exercise regularly? Y / N

Please describe your exercise program:

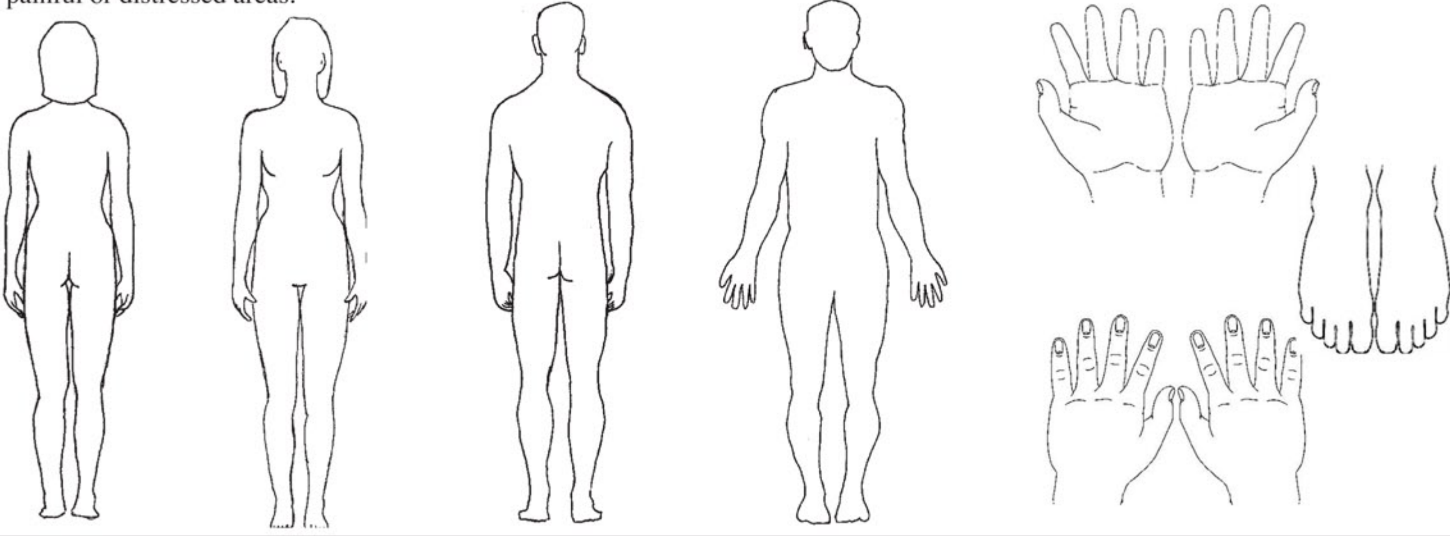
How many hours do you sleep: __________

When do you usually go to bed? __________

Do you smoke? Y / N if Y, then what? ____________________ How many per day? __________ Since when? __________

Please describe any use of drugs for non-medical purposes:

Indicate painful or distressed areas:



Women

Age of first menses:__________ First date of last period __________ Duration of periods __________days, cycle __________days

__________ # of pregnancies __________# of births __________miscarriages __________Abortions

__________Premature Births __________Cesarian sections __________Difficulty delivery

Do you practice birth control? Y / N If yes, what type and for how long? ____________________

Please Check if you have had any of the following conditions in the last 3 months:

Metabolism ○ Night sweats ○ Sweat easily ○ Poor appetite ○ Cravings ○ Change in appetite
○ Desires cold food ○ Craves hot food ○ Peculiar tastes ○ Strong thirst ○ Weight loss ○ Weight gain
○ Sudden energy drop ○ Fatigue ○ Localized weakness ○ Tremors ○ Poor sleeping ○ Poor balance
○ Bleed or bruise easily ○ Fevers ○ Chills ○ Other:__________________

Skin ○ Acne ○ Rashes ○ Dandruff ○ Changes in hair or skin ○ Ulcerations ○ Dry skin ○ Hives
○ Recent moles ○ Itching ○ Loss of hair ○ Eczema ○ Purpura ○ Other:__________________

Musculo-skeletal ○ Difficulty Walking ○ Numbness ○ Hand/wrist pain ○ Joint disorders ○ Cold hands/feet
○ Tingling ○ Hip pain ○ Muscle Weakness ○ Swelling of hand/feet ○ Knee pain ○ Muscles pain/soreness
○ Back pain ○ Neck tightness ○ Sprain of joint ○ Spinal curvature ○ Neck pain ○ Hernia ○ Shoulder pain
○ Other:__________________

Eyes ○ Eye strain ○ Eye Pain ○ Blurry Vision ○ Color blindness ○ Night blindness
○ Poor vision ○ Glasses / Contacts ○ Cataracts ○ Other:__________________

Ear ○ Dizziness ○ Concussions ○ Migraines ○ Earaches ○ Ringing in ears ○ Poor hearing
○ Spots in front of eyes ○ Other:__________________

Nose ○ Sinus Problems ○ Nose bleeding ○ Sore Throat (chronic) ○ Other:__________________

Throat ○ Difficulty swallowing ○ Other:__________________

Teeth ○ Grinding teeth ○ Teeth problems ○ Other:__________________

Face / Head ○ Facial pain ○ Jaw clicks ○ Sores on lips/tongue ○ Other:__________________

Lung ○ Cough ○ Coughing blood ○ Wheezing ○ Difficulty breathing ○ Bronchitis ○ Pneumonia
○ Chest pain ○ Production of phlegm, color __________, thick/thin ○ Other:__________________

GI ○ Nausea ○ Vomiting ○ Diarrhea ○ Constipation ○ Gas ○ Belching ○ Black stools
○ Blood in stools ○ Indigestion ○ Bad breath ○ Rectal pain ○ Hemorrhoids ○ Abdominal pain/cramps
○ Gallbladder problems ○ Parasites ○ Chronic laxative use ○ Other:__________________

Circulatory ○ Palpitations ○ High / low blood pressure ○ Chest pain ○ Fainting ○ Phlebitis
○ Irregular / rapid heartbeat ○ Varicose veins ○ Other:__________________

Urinary
○ Pain on urination ○ Frequent urination ○ Blood in urine ○ Urgent to urinate ○ Kidney stones
○ Unable to hold urine ○ Dribbling ○ Pause of flow ○ Chronic urinary tract infection ○ Pain in genital
○ Itching of genital ○ Other:__________________

Neurological ○ Loss of balance ○ Lack of coordination ○ Depression ○ Anxiety ○ Grief ○ Stress
○ Irritable / Bad Temper ○ Bi-polar ○ Other:__________________

Reproductive ○ Lack of interest ○ STD's ○ History of abuse ○ Other:__________________

Women ○ Frequent vaginal infections ○ Pelvic infections ○ Endometriosis ○ Vaginal/genital discharge ○ Fibroids
○ Ovarian cysts ○ Irregular periods ○ Clots ○ Pain/cramps prior/during periods ○ Breast tenderness
○ Breast lumps ○ Fertility problems ○ Hot flashes ○ Moodiness related to periods ○ Other:__________________

Men ○ Prostate problems ○ Discharge ○ Impotence ○ Frequent seminal emission ○ Fertility problems
○ Ejaculation problems ○ Painful/swollen testicles ○ Other:__________________

Medications, Vitamins/Supplements and Herbal Medicines

Medication	Taking For?	For How Long?	Dosage?

Vitamin/Supplement	Taking For?	For How Long?	Dosage?

Herbal Supplements	Taking For?	For How Long?	Dosage?

Dietary Therapy? ______________________________

____

____