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## HABITS

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### EXERCISE/SELF CARE:-

<input type="checkbox"/> Acupressure	<input type="checkbox"/> Exercise	<input type="checkbox"/> Myofascial Release	<input type="checkbox"/> See medications	<input type="checkbox"/> Topical prep
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Heat	<input type="checkbox"/> Pacing activities	<input type="checkbox"/> Sauna	<input type="checkbox"/> Traction
<input type="checkbox"/> Alpha Stim	<input type="checkbox"/> Hot tub/Shower	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Sombra	<input type="checkbox"/> Walking/treadmill
<input type="checkbox"/> Bicycling	<input type="checkbox"/> Ice	<input type="checkbox"/> Prayer	<input type="checkbox"/> Stretching	<input type="checkbox"/> Water Aerobics
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Massage	<input type="checkbox"/> Relaxation	<input type="checkbox"/> Tai Chi	<input type="checkbox"/> Weight training
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Meditation	<input type="checkbox"/> Running	<input type="checkbox"/> TENS	<input type="checkbox"/> Yoga

#### Frequency of exercise:

<input type="checkbox"/> 1x week	<input type="checkbox"/> 5-6x week
<input type="checkbox"/> 2x week	<input type="checkbox"/> Every other day
<input type="checkbox"/> 3x week	<input type="checkbox"/> Daily
<input type="checkbox"/> 4-5x week	

#### Time per session:

<input type="checkbox"/> 5 minutes	<input type="checkbox"/> 30 minutes
<input type="checkbox"/> 10 minutes	<input type="checkbox"/> 45 minutes
<input type="checkbox"/> 15 minutes	<input type="checkbox"/> 60 minutes
<input type="checkbox"/> 20 minutes	<input type="checkbox"/> 90 minutes

### SUBSTANCE USE:-

**Tobacco use:**  Never smoked       Former smoker       Daily smoker  
 Sometimes smoker       Smokeless tobacco (dips)

**Frequency:** How much do you smoke/dip? \_\_\_\_\_/per day

**Tobacco cessation:**  None     Receive counseling     Use drugs (patch, gum, etc)

**Alcohol:** \_\_\_\_\_/per (circle frequency) day / week / month

**Caffeine:** \_\_\_\_\_ cups/day.

**Marijuana:** \_\_\_\_\_/day.

**Herbals:** \_\_\_\_\_

### SLEEP HABITS:

**Hours per night:** \_\_\_\_\_    **Refreshing:** yes or no    **Awaken # time:** \_\_\_\_\_    **Naps per day:** \_\_\_\_\_

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## RECENT MEDICAL

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### Have you experienced any of the following IN THE PAST 4 WEEKS:

**Gen:** Appetite change \_\_. Fatigue \_\_. Weakness \_\_. Weight gain \_\_. Weight loss \_\_.

**HEENT:** Bloody nose \_\_. Blurry vision \_\_. Eye pain \_\_. Headache \_\_. Nasal discharge \_\_.  
Ringing in ears \_\_. Sinus infection \_\_. Sore throat \_\_.

**Resp:** Chest pain \_\_. Cough \_\_. Cough up blood \_\_. Cough up phlegm \_\_. Shortness of breath \_\_.

**CV:** Chest pain with exercise \_\_. Pass out when standing up \_\_.

**GI:** Abdominal pain \_\_. Blood in stool \_\_. Constipation \_\_. Diarrhea \_\_. Nausea \_\_. Vomiting \_\_.

**GU:** Blood in urine \_\_. Pain on urination \_\_. Sexual dysfunction \_\_. Urinary incontinence \_\_.  
Urinary infection \_\_.

**B&J:** Joint stiffness \_\_. Muscle or joint pain \_\_. Swollen joints \_\_.

**Neuro:** Arm or leg weakness \_\_. Dizziness \_\_. Fainting \_\_. Numbness \_\_. Seizures/convulsions \_\_.  
Tingling \_\_. Vertigo \_\_. Visual problems \_\_.

**Skin:** Itching \_\_. Moles or growths \_\_. Rash \_\_.

### LABS

#### **Please list recent lab work:**

Date: \_\_\_\_\_ Name of Lab: \_\_\_\_\_ Where performed: \_\_\_\_\_

Date: \_\_\_\_\_ Name of Lab: \_\_\_\_\_ Where performed: \_\_\_\_\_

#### **Please list recent imaging (x-ray, MRI, CT, bone scan, etc):**

Date: \_\_\_\_\_ Name of Imaging: \_\_\_\_\_ Body part: \_\_\_\_\_ Where performed: \_\_\_\_\_

Date: \_\_\_\_\_ Name of Imaging: \_\_\_\_\_ Body part: \_\_\_\_\_ Where performed: \_\_\_\_\_

**When did you last see your Primary Care Provider?** \_\_\_\_\_