



# dr. kurt's place

functional chiropractic & lifestyle medicine

**Dr. Kurt Perkins DC CCWP CFMP**

4239 N. Nevada Ave. Suite 104.

Colorado Springs, CO 80907

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Hello@DrKurtPerkins.com

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
&  
COMPREHENSIVE HEALTH HISTORY FORMS**

**4239 N. Nevada Ave. Suite 104**

**Colorado Springs, CO 80907**

**719-602-4545**

**www.MoreHealthLessHealthCare.com**

**Hello@DrKurtPerkins.com**

## **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Requesting records of Dr. \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number ( ) \_\_\_\_ - \_\_\_\_\_

Fax number ( ) \_\_\_\_ - \_\_\_\_\_

### **THE PURPOSE FOR THIS RELEASE**

You are hereby authorized to furnish and release to \_\_\_\_\_

all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ☐ Yes ☐ No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: ☐ Yes ☐ No

Genetic Testing ☐ Yes ☐ No

*Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.*

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release \_\_\_\_\_

(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

*Please Print*

Signature: \_\_\_\_\_

Date \_\_\_\_\_

### **Records Requested by:**

Doctor's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

## COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ -

\_\_\_\_\_

Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of birth \_\_\_\_\_ Gender:

Female\_\_Male\_\_

City or town & country, if not US

Referred by: \_\_\_\_\_

Name, address, & phone number of primary care physician: \_\_\_\_\_

\_\_\_\_\_

Marital Status:

Single\_\_\_\_ Married\_\_\_\_ Divorced\_\_\_\_ Widowed\_\_\_\_ Long Term Partnership\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship

Name

Phone

\_\_\_\_\_

Address

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_

Retired \_\_\_\_\_

Nature of Business \_\_\_\_\_

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Genetic Background: Please check appropriate box(es):

- ☐ African America   ☐ Hispanic   ☐ Mediterranean   ☐ Asian  
☐ Native American   ☐ Caucasian   ☐ Northern European   ☐ Other

### **CURRENT HEALTH STATUS/CONCERNS**

Please provide us with current and ongoing problems

<b>Problem</b>	<b>Date of Onset</b>	<b>Severity/Frequency</b>	<b>Treatment Approach</b>	<b>Success</b>
<b>Example:</b> Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

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When was the last time that you felt fantastic? \_\_\_\_\_

What seems to trigger your symptoms? \_\_\_\_\_

What seems to worsen your symptoms? \_\_\_\_\_

What seems to make you feel better? \_\_\_\_\_

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions? \_\_\_\_\_

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How much time have you lost from work or school in the past year due to these conditions? \_\_\_\_\_

### **PAST MEDICAL AND SURGICAL HISTORY**

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

<b>ILLNESSES</b>	<b>WHEN /ONSET</b>	<b>COMMENTS</b>
Anemia		
Arthritis		
Asthma		

Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
<b>ILLNESS</b>	<b>WHEN/ONSET</b>	<b>COMMENTS</b>
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
<b>INJURIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		

Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	WHEN	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

### HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

## MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

**List all medications. Include all over the counter non-prescription drugs.**

Medication Name	Date started	Date stopped	Dosage

**List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.**

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes\_\_\_\_ No \_\_\_\_

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If yes, please list: \_\_\_\_\_

### CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Were you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

### IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				



## CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes\_\_\_ No\_\_\_

If yes, please explain: (Example: milk – diarrhea)\_\_\_\_\_

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## CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		
Measles		

As a child did you: Have a high absence from school?

Yes\_\_\_ No\_\_\_

If yes, why?\_\_\_\_\_

Experience chronic exposure to second hand smoke in your home?

Yes\_\_\_ No\_\_\_

Experience abuse

Yes\_\_\_ No\_\_\_

Have alcoholic parents?

Yes\_\_\_ No\_\_\_

## FEMALE MEDICAL HISTORY

(For women only)

### OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pregnancies_____            | <input type="checkbox"/> Cesarean<br>_____ | <input type="checkbox"/> Vaginal<br>deliveries_____   |
| <input type="checkbox"/> Miscarriage<br>_____        | <input type="checkbox"/> Abortion<br>_____ | <input type="checkbox"/> Living<br>Children_____      |
| <input type="checkbox"/> Post partum depression_____ | <input type="checkbox"/> Toxemia<br>_____  | <input type="checkbox"/> Gestational<br>diabetes_____ |

### GYNECOLOGICAL HISTORY

Age at first menses?\_\_\_\_\_ Frequency:\_\_\_\_\_ Length:\_\_\_\_\_

Painful: Yes\_\_\_\_\_ No\_\_\_\_\_ Clotting: Yes\_\_\_\_\_ No\_\_\_\_\_

Date of last menstrual period:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Do you currently use contraception? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, what please indicate which form:

Non-hormonal

- ☐ Condom
- ☐ Diaphragm
- ☐ IUD
- ☐ Partner vasectomy
- ☐ Other (non-hormonal-please describe)\_\_\_\_\_

Hormonal

- ☐ Birth control pills
- ☐ Patch
- ☐ Nuva Ring
- ☐ Other (please describe)\_\_\_\_\_

Even if you are not currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long.\_\_\_\_\_

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes \_\_\_\_\_ No \_\_\_\_\_

Please advise of any other symptoms that you feel are significant.\_\_\_\_\_

\_\_\_\_\_

Are you menopausal? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, age of menopause\_\_\_\_\_

Do you currently take hormone replacement? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, what type and for how long?\_\_\_\_\_

- |   |                               |                                  |                                   |                                       |                                  |
|---|-------------------------------|----------------------------------|-----------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Estrogen       | <input type="checkbox"/> Ogen | <input type="checkbox"/> Estrace | <input type="checkbox"/> Premarin | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Provera |
| <input type="checkbox"/> Other<br>_____ |                               |                                  |                                   |                                       |                                  |

### DIAGNOSTIC TESTING

Last PAP test:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Normal:\_\_\_\_\_Abnormal\_\_\_\_\_

Last Mammogram\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Breast biopsy? Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of last bone density\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Results: High\_\_\_\_\_ Low\_\_\_\_\_ Within normal range\_\_\_\_\_

### **FAMILY HEALTH HISTORY**

Please indicate current and past history to the best of your knowledge

<b>Check Family Members that Apply</b>	<b>Father</b>	<b>Mother</b>	<b>Brother(s)</b>	<b>Sister(s)</b>	<b>Children</b>	<b>Maternal Grandmother</b>	<b>Maternal Grandfather</b>	<b>Paternal Grandmother</b>	<b>Paternal Grandfather</b>
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									

Emphysema									
Environmental Sensitivities									
<b>Check Family Members that Apply</b>	<b>Father</b>	<b>Mother</b>	<b>Brother(s)</b>	<b>Sister(s)</b>	<b>Children</b>	<b>Maternal Grandmother</b>	<b>Maternal Grandfather</b>	<b>Paternal Grandmother</b>	<b>Paternal Grandfather</b>
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

## REVIEW OF SYMPTOMS

**Check (✓)** those items that applied to you in the ***past***. **Circle** those that ***presently*** apply

### **GENERAL**

- ☐ Fever
- ☐ Chills/Cold all over
- ☐ Aches/Pains
- ☐ General Weakness
- ☐ Difficulty sweating
- ☐ Excessive Sweating
- ☐ Swollen Glands
- ☐ Cold hands & Feet
- ☐ Fatigue
- ☐ Difficulty falling asleep
- ☐ Sleepwalker
- ☐ Nightmares
- ☐ No dream recall
- ☐ Early waking
- ☐ Daytime sleepiness
- ☐ Distorted vision

### **SKIN:**

- ☐ Cuts heal slowly
- ☐ Bruise easily
- ☐ Rashes
- ☐ Pigmentation
- ☐ Changing Moles
- ☐ Calluses
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dryness/cracking skin
- ☐ Oiliness
- ☐ Itching
- ☐ Acne
- ☐ Boils
- ☐ Hives
- ☐ Fungus on Nails
- ☐ Peeling Skin
- ☐ Shingles
- ☐ Nails Split
- ☐ White Spots/Lines on Nails
- ☐ Crawling Sensation
- ☐ Burning on Bottom of Feet
- ☐ Athletes Foot
- ☐ Cellulite
- ☐ Bugs love to bite you
- ☐ Bumps on back of arms & front of thighs
- ☐ Skin cancer
- ☐ Strong body odor

#### **Is your skin sensitive to:**

- ☐ Sun
- ☐ Fabrics
- ☐ Detergents
- ☐ Lotions/Creams

### **HEAD:**

- ☐ Poor Concentration
- ☐ Confusion
- ☐ Headaches:
  - ☐ After Meals
  - ☐ Severe
  - ☐ Migraine
  - ☐ Frontal
  - ☐ Afternoon
  - ☐ Occipital
  - ☐ Daytime
  - ☐ Relieved by:
    - ☐ Eating Sweets
- ☐ Concussion/Whiplash
- ☐ Mental sluggishness
- ☐ Forgetfulness
- ☐ Indecisive
- ☐ Face twitch
- ☐ Poor memory
- ☐ Hair loss

### **EYES:**

- ☐ Feeling of sand in eyes
- ☐ Double vision
- ☐ Blurred vision
- ☐ Poor night vision
- ☐ See bright flashes
- ☐ Halo around lights
- ☐ Eye pains
- ☐ Dark circles under eyes
- ☐ Strong light irritates
- ☐ Cataracts
- ☐ Floaters in eyes
- ☐ Visual hallucinations

### **EARS:**

- ☐ Aches
- ☐ Discharge/Conjunctivitis
- ☐ Pains
- ☐ Ringing
- ☐ Deafness/Hearing loss
- ☐ Itching
- ☐ Pressure
- ☐ Hearing aid
- ☐ Frequent infections
- ☐ Tubes in ears
- ☐ Sensitive to loud noises
- ☐ Hearing hallucinations

### **NOSE/SINUSES**

- ☐ Stuffy
- ☐ Bleeding
- ☐ Running/Discharge
- ☐ Watery nose
- ☐ Congested
- ☐ Infection
- ☐ Polyps
- ☐ Acute smell
- ☐ Drainage
- ☐ Sneezing spells
- ☐ Post nasal drip
- ☐ No sense of smell
- ☐ Do the change of seasons tend to make your symptoms worse? Yes/No

**If yes, is it worse in the:**

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter

**MOUTH:**

- ☐ Coated tongue
- ☐ Sore tongue
- ☐ Teeth problems
- ☐ Bleeding gums
- ☐ Canker sores
- ☐ TMJ
- ☐ Cracked lips/ corners
- ☐ Chapped lips
- ☐ Fever blisters
- ☐ Wear dentures
- ☐ Grind teeth when sleeping
- ☐ Bad breath
- ☐ Dry mouth

**THROAT:**

- ☐ Mucus
- ☐ Difficulty swallowing
- ☐ Frequent hoarseness
- ☐ Tonsillitis
- ☐ Enlarged glands
- ☐ Constant clearing of throat
- ☐ Throat closes up

**NECK:**

- ☐ Stiffness
- ☐ Swelling
- ☐ Lumps
- ☐ Neck glands swell

**CIRCULATION/RESPIRATION:**

- ☐ Swollen ankles
- ☐ Sensitive to hot
- ☐ Sensitive to cold

- ☐ Extremities cold or clammy
- ☐ Hands/Feet go to sleep/numbness/tingling
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Pain between shoulders
- ☐ Dizziness upon standing
- ☐ Fainting spells
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ Wheezing
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Low exercise tolerance
- ☐ Frequent coughs
- ☐ Breathing heavily
- ☐ Frequently sighing
- ☐ Shortness of breath
- ☐ Night sweats
- ☐ Varicose veins/spider veins
- ☐ Mitral valve prolapse
- ☐ Murmurs
- ☐ Skipped heartbeat
- ☐ Heart enlargement
- ☐ Angina pain
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema
- ☐ Croup
- ☐ Frequent colds
- ☐ Heavy/tight chest
- ☐ Prior heart attack ? When\_\_\_\_/\_\_\_\_/\_\_\_\_
- ☐ Phlebitis

**GASTROINTESTINAL**

- ☐ Peptic/Duodenal Ulcer
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Gallstones
- ☐ Gallbladder pain

- ☐ Nervous stomach
- ☐ Full feeling after small meal
- ☐ Indigestion
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Hiatal Hernia
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Abdominal Pains/Cramps
- ☐ Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Changes in bowels
- ☐ Rectal bleeding
- ☐ Tarry stools
- ☐ Rectal itching
- ☐ Use laxatives
- ☐ Bloating
- ☐ Belch frequently
- ☐ Anal itching
- ☐ Anal fissures
- ☐ Bloody stools
- ☐ Undigested food in stools

#### **KIDNEY/URINARY TRACT:**

- ☐ Burning
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Night time urination
- ☐ Problem passing urine
- ☐ Kidney pain
- ☐ Kidney stones
- ☐ Painful urination
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Syphilis
- ☐ Bedwetting
- ☐ Have trichomonas

#### **WOMEN'S HISTORY (for women only)**

- ☐ Fibrocystic breasts
- ☐ Lumps in breast
- ☐ Fibroid Tumors/Breast
- ☐ Spotting
- ☐ Heavy periods
- ☐ Fibroid Tumors/Uterus

#### **WOMEN'S HISTORY (for women only)**

- ☐ Painful periods
- ☐ Change in period
- ☐ Breast soreness before period
- ☐ Endometriosis
- ☐ Non-period bleeding
- ☐ Breast soreness during period
- ☐ Vaginal dryness
- ☐ Vaginal discharge

- ☐ Partial/total hysterectomy
- ☐ Hot flashes
- ☐ Mood swings
- ☐ Concentration/Memory Problems
- ☐ Breast cancer
- ☐ Ovarian cysts
- ☐ Pregnant
- ☐ Infertility
- ☐ Decreased libido
- ☐ Heavy bleeding
- ☐ Joint pains
- ☐ Headaches
- ☐ Weight gain
- ☐ Loss of bladder control
- ☐ Palpitations

#### **MEN'S HISTORY (for men only)**

Have you had a PSA done?

Yes \_\_\_\_\_ No \_\_\_\_\_

PSA Level:

- ☐ 0 – 2
- ☐ 2 – 4
- ☐ 4 – 10
- ☐ >10

- ☐ Prostate enlargement
- ☐ Prostate infection
- ☐ Change in libido
- ☐ Impotence
- ☐ Diminished/poor libido
- ☐ Infertility
- ☐ Lumps in testicles
- ☐ Sore on penis
- ☐ Genital pain
- ☐ Hernia
- ☐ Prostate cancer
- ☐ Low sperm count
- ☐ Difficulty obtaining erection
- ☐ Difficulty maintaining an erection
- ☐ Nocturia (urination at night)
  - ☐ How many times at night?  
\_\_\_\_\_

- ☐ Urgency/Hesitancy/Change in Urinary Stream
- ☐ Loss of bladder control

#### **JOINT/MUSCLES/TENDONS**

- ☐ Pain wakes you
- ☐ Weakness in legs and arms
- ☐ Balance problems
- ☐ Muscle cramping
- ☐ Head injury
- ☐ Muscle stiffness in morning
- ☐ Damp weather bothers you

### EMOTIONAL:

- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Blackouts/Amnesia
- ☐ Had prior shock therapy
- ☐ Frequently keyed up and jittery
- ☐ Startled by sudden noises
- ☐ Anxiety/Feeling of panic
- ☐ Go to pieces easily
- ☐ Forgetful
- ☐ Listless/groggy
- ☐ Withdrawn feeling/Feeling 'lost'
- ☐ Had nervous breakdown
- ☐ Unable to concentrate/short attention span
- ☐ Vision changes
- ☐ Unable to reason
- ☐ Considered a nervous person by others
- ☐ Tends to worry needlessly
- ☐ Unusual tension

- ☐ Often break out in cold sweats
- ☐ Profuse sweating
- ☐ Depressed
- ☐ Previously admitted for psychiatric care
- ☐ Often awakened by frightening dreams
- ☐ Family member had nervous breakdown
- ☐ Use tranquilizers
- ☐ Misunderstood by others
- ☐ Irritable/
- ☐ Feeling of hostility/volatile or aggressive
- ☐ Fatigue
- ☐ Hyperactive
- ☐ Restless leg syndrome
- ☐ Considered clumsy
- ☐ Unable to coordinate muscles
- ☐ Have difficulty falling asleep
- ☐ Have difficulty staying asleep
- ☐ Daytime sleepiness
- ☐ Am a workaholic
- ☐ Have had hallucinations
- ☐ Have considered suicide
- ☐ Have overused alcohol
- ☐ Family history of overused alcohol
- ☐ Cry often
- ☐ Feel insecure
- ☐ Have overused drugs
- ☐ Been addicted to drugs
- ☐ Extremely shy

### EMOTIONAL (CONTINUED)

- ☐ Frustration
- ☐ Emotional numbness

## PAIN ASSESSMENT

Are you currently in pain? Yes \_\_\_\_ No \_\_\_\_

Is the source of your pain due to an injury? Yes \_\_\_\_ No \_\_\_\_

**If yes**, please describe your injury and the date in which it occurred: \_\_\_\_\_

**If no**, please describe how long you have experienced this pain and what you believe it is attributed to: \_\_\_\_\_

Please use the area(s) and illustration below to describe the severity of your pain.

(0= no pain, 10= severe pain)

Example: Neck

0 1 2 3 4 5 6 7 8 9 10

Area 1. \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Area 2. \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Area 3. \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

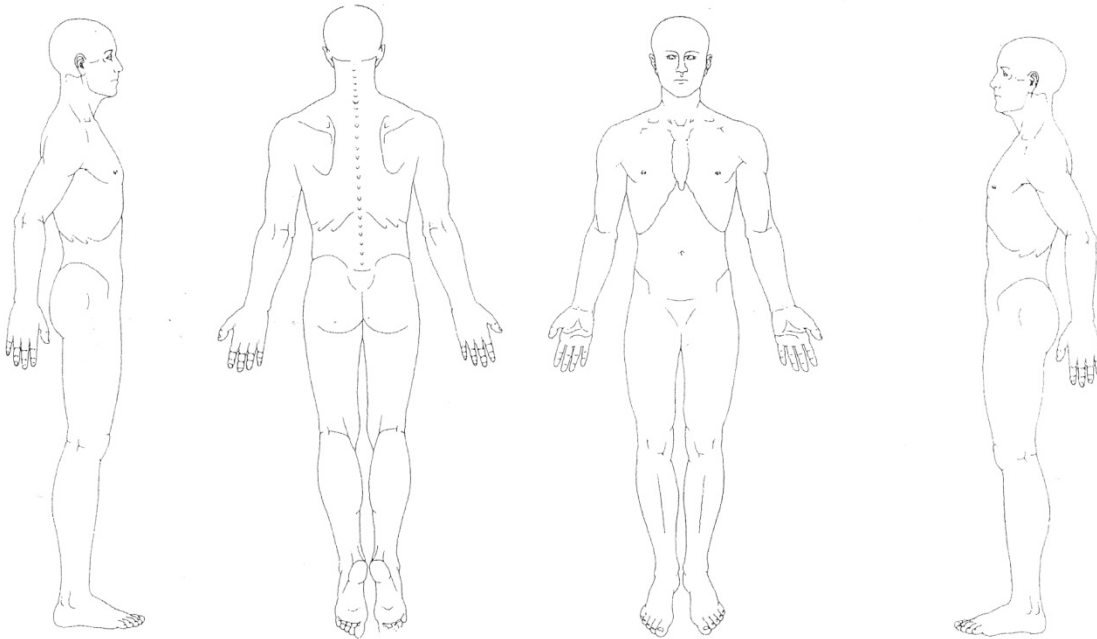
Area 4. \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10



Use the letters provided to mark your area(s) of pain on the illustration.

**A** = ache      **B**= burning      **N**=numbness      **S**= stiffness      **T**=tingling      **Z**=sharp/shooting



Right Side

Back

Front

Left side

### **DENTAL HISTORY**

	<u><b>Yes</b></u>	<u><b>No</b></u>
Problem with sore gums (gingivitis)?	_____	_____
ringing in the ears (tinnitus)?	_____	_____
Have TMJ (temporal mandibular joint) problems?	_____	_____
Metallic taste in mouth?	_____	_____
Problems with bad breath (halitosis) or white tongue (thrush)?	_____	_____
Previously or currently wear braces?	_____	_____
Problems chewing?	_____	_____
Floss regularly?	_____	_____
Do you have amalgam dental fillings? How many?	_____	_____
Did you receive these fillings as a child?	_____	_____

List your approximate age and the type of dental work done from childhood until present:

<b>Age</b>	<b>Type of dental work:</b>	<b>Health Problems following dental work? (describe)</b>


## NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes\_\_\_\_\_ No\_\_\_\_\_

## **FOOD DIARY**

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Bacon/Sausage	<input type="checkbox"/> Butter	<input type="checkbox"/> Beans (legumes)
<input type="checkbox"/> Bagel	<input type="checkbox"/> Coffee	<input type="checkbox"/> Brown rice
<input type="checkbox"/> Butter	<input type="checkbox"/> Eat in a cafeteria	<input type="checkbox"/> Butter
<input type="checkbox"/> Cereal	<input type="checkbox"/> Eat in restaurant	<input type="checkbox"/> Carrots
<input type="checkbox"/> Coffee	<input type="checkbox"/> Fish sandwich	<input type="checkbox"/> Coffee
<input type="checkbox"/> Donut	<input type="checkbox"/> Fried foods	<input type="checkbox"/> Fish
<input type="checkbox"/> Eggs	<input type="checkbox"/> Hamburger	<input type="checkbox"/> Green vegetables
<input type="checkbox"/> Fruit	<input type="checkbox"/> Hot dogs	<input type="checkbox"/> Juice
<input type="checkbox"/> Juice	<input type="checkbox"/> Juice	<input type="checkbox"/> Margarine
<input type="checkbox"/> Margarine	<input type="checkbox"/> Leftovers	<input type="checkbox"/> Milk
<input type="checkbox"/> Milk	<input type="checkbox"/> Lettuce	<input type="checkbox"/> Pasta
<input type="checkbox"/> Oat bran	<input type="checkbox"/> Margarine	<input type="checkbox"/> Potato
<input type="checkbox"/> Sugar	<input type="checkbox"/> Mayo	<input type="checkbox"/> Poultry
<input type="checkbox"/> Sweet roll	<input type="checkbox"/> Meat sandwich	<input type="checkbox"/> Red meat
<input type="checkbox"/> Sweetener	<input type="checkbox"/> Milk	<input type="checkbox"/> Rice
<input type="checkbox"/> Tea	<input type="checkbox"/> Pizza	<input type="checkbox"/> Salad
<input type="checkbox"/> Toast	<input type="checkbox"/> Potato chips	<input type="checkbox"/> Salad dressing
<input type="checkbox"/> Water	<input type="checkbox"/> Salad	<input type="checkbox"/> Soda
<input type="checkbox"/> Wheat bran	<input type="checkbox"/> Salad dressing	<input type="checkbox"/> Sugar
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Soda	<input type="checkbox"/> Sweetener
<input type="checkbox"/> Oat meal	<input type="checkbox"/> Soup	<input type="checkbox"/> Tea
<input type="checkbox"/> Milk protein shake	<input type="checkbox"/> Sugar	<input type="checkbox"/> Vinegar
<input type="checkbox"/> Slim fast	<input type="checkbox"/> Sweetener	<input type="checkbox"/> Water
<input type="checkbox"/> Carnation shake	<input type="checkbox"/> Tea	<input type="checkbox"/> White rice
<input type="checkbox"/> Soy protein	<input type="checkbox"/> Tomato	<input type="checkbox"/> Yellow vegetables
<input type="checkbox"/> Whey protein	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Other: (List below)
<input type="checkbox"/> Rice protein	<input type="checkbox"/> Water	
<input type="checkbox"/> Other: (List below)	<input type="checkbox"/> Yogurt	
	<input type="checkbox"/> Slim fast	
	<input type="checkbox"/> Carnation shake	
	<input type="checkbox"/> Protein shake	

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes\_\_\_\_\_ No\_\_\_\_\_

☐ Ovo-lacto

☐ Vegetarian

☐ Diabetic

☐ Vegan

☐ Dairy restricted

☐ Blood type diet

☐ Other (describe)\_\_\_\_\_

Please tell us if there is anything special about your diet that we should know.\_\_\_\_\_

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, are these symptoms associated with any particular food or supplement?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please name the food or supplement and symptom(s). \_\_\_\_\_

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)

Yes\_\_\_\_\_ No\_\_\_\_\_

Do you feel **worse** when you eat a lot of:

☐ High fat foods

☐ Refined sugar (junk food)

☐ High protein foods

☐ Fried foods

☐ High carbohydrate foods (breads, pasta, potatoes)

☐ 1 or 2 alcoholic drinks

☐ Other\_\_\_\_\_

Do you feel **better** when you eat a lot of:

☐ High fat foods

☐ Refined sugar (junk food)

☐ High protein foods

☐ Fried foods

☐ High carbohydrate foods (breads, pasta, potatoes)

☐ 1 or 2 alcoholic drinks

☐ Other\_\_\_\_\_

Does skipping meals greatly affect your symptoms? Yes \_\_\_\_\_ No \_\_\_\_\_

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what food(s)

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Do you have an aversion to certain foods? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what food(s)

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Please complete the following chart as it relates to your bowel movements:

Frequency	✓	Color	✓
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	✓	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

- ☐ Daily
- ☐ Occasionally
- ☐ Excessive
- ☐ Present with pain
- ☐ Foul smelling
- ☐ Little odor

## LIFESTYLE HISTORY

### TOBACCO HISTORY

Have you ever used tobacco? Yes \_\_\_\_ No \_\_\_\_

If yes, what type? Cigarette \_\_\_\_ Smokeless \_\_\_\_ Cigar \_\_\_\_ Pipe \_\_\_\_ Patch/Gum \_\_\_\_

How much? \_\_\_\_\_

Number of years? \_\_\_\_\_ If not a current user, year quit \_\_\_\_\_

Attempts to quit: \_\_\_\_\_

Are you exposed to 2<sup>nd</sup> hand smoke regularly? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

### ALCOHOL INTAKE

Have you ever used alcohol? Yes \_\_\_\_ No \_\_\_\_

If yes, how often do you now drink alcohol?

- ☐ No longer drink alcohol
- ☐ Average 1-3 drinks per week
- ☐ Average 4-6 drinks per week
- ☐ Average 7-10 drinks per week
- ☐ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you “hold” more than others?) Yes \_\_\_\_ No \_\_\_\_

Have you ever had a problem with alcohol? Yes \_\_\_\_ No \_\_\_\_

If yes, indicate time period (month/year) From \_\_\_\_\_ to \_\_\_\_\_

### OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes \_\_\_\_ No \_\_\_\_

If yes, what type(s) and method? (IV, inhaled, smoked, etc) \_\_\_\_\_

\_\_\_\_\_

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes \_\_\_\_ No \_\_\_\_

If yes, indicate which

- ☐ Lead
- ☐ Arsenic
- ☐ Aluminum
- ☐ Cadmium
- ☐ Mercury

### SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10 \_\_\_\_ 8-10 \_\_\_\_ 6-8 \_\_\_\_ less than 6 \_\_\_\_

Do you:

- |   |   |
|---|---|
| <input type="checkbox"/> Have trouble falling asleep? | <input type="checkbox"/> Snore?             |
| <input type="checkbox"/> Feel rested upon waking?     | <input type="checkbox"/> Use sleeping aids? |
| <input type="checkbox"/> Have problems with insomnia? |   |

Dr. Kurt Perkins DC CCWP FMT | Dr. Kurt's Place | 4239 N. Nevada Ave. #104, Colorado Springs, CO 80907

## EXERCISE HISTORY

Do you exercise regularly? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please indicate:

Type of exercise	Times/week				Length of session			
	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

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## SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

## STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes\_\_\_\_\_ No\_\_\_\_\_

Do you feel you can easily handle the stress in your life? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, do you believe that stress is presently reducing the quality of your life? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, do you believe that you know the source of your stress? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what do you believe it to be?\_\_\_\_\_

Have you ever contemplated suicide? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, how often? \_\_\_\_\_ When was the last time? \_\_\_\_\_

Have you ever sought help through counseling? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, what type? (e.g., pastor, psychologist, etc)\_\_\_\_\_

Did it help? \_\_\_\_\_

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

☐ Spouse   ☐ Family   ☐ Friends   ☐ Religious/Spiritual   ☐ Pets   ☐ Other \_\_\_\_\_

Have you ever been involved in abusive relationships in your life? Yes \_\_\_\_ No \_\_\_\_

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes \_\_\_\_ No \_\_\_\_

Did you feel safe growing up? Yes \_\_\_\_ No \_\_\_\_

Was alcoholism or substance abuse present in your childhood home? Yes \_\_\_\_ No \_\_\_\_

Is alcoholism or substance abuse present in your relationships now? Yes \_\_\_\_ No \_\_\_\_

How important is religion (or spirituality) for you and your family's life?

a. \_\_\_\_ not at all important   b. \_\_\_\_ somewhat important   c. \_\_\_\_ extremely important

Do you practice meditation or relaxation techniques? Yes \_\_\_\_ No \_\_\_\_

If yes, how often? \_\_\_\_\_

Check all that apply:

☐ Yoga   ☐ Meditation   ☐ Imagery   ☐ Breathing   ☐ Tai Chi   ☐ Prayer   ☐ Other  
r

Hobbies and leisure activities:

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Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes \_\_\_\_ No \_\_\_\_

## READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 _____	4 _____	3 _____	2 _____	1 _____
Take nutritional supplements each day	5 _____	4 _____	3 _____	2 _____	1 _____
Keep a record of everything you eat each day	5 _____	4 _____	3 _____	2 _____	1 _____
Modify your lifestyle (e.g. work demands, sleep habits)	5 _____	4 _____	3 _____	2 _____	1 _____
Practice relaxation techniques	5 _____	4 _____	3 _____	2 _____	1 _____
Engage in regular exercise	5 _____	4 _____	3 _____	2 _____	1 _____
Have periodic lab tests to assess progress	5 _____	4 _____	3 _____	2 _____	1 _____
Comments					

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well being.

Sincerely,

*Dr. Kurt,*