Name:_____ Date:_____

Physical Generals and Review of Systems

(Parents should fill out this form for young children based on observation. Children over 4 or 5 years old can be asked some of the questions. Please then write their answers, plus your own observations).

FOOD:

1. What foods do you especially like, or crave (even if you don't eat them)?

2. What foods do you dislike?

3. What foods disagree with or aggravate you in some way?

4. How is your appetite? Poor, average, high? Specify.

5. Any problems with digestion? Specify.

6. Any problems if you go too long without eating (headache, shakiness, etc.), and how many hours can you go without eating before getting these symptoms?

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Thermal State:

1. Which do you tolerate the LEAST: extreme hot weather, or extreme cold weather? Please specify if either causes or aggravates any symptoms.

Is this a lifelong tendency, or has it changed in recent years?

2. Are you affected by a draft of air? How?

3. Does any particular weather affect you (rainy/damp, hot and humid, dry, windy, etc.)? How?

4. How do you like or tolerate the direct sun? Any symptoms if in it too long?

5. Do thunderstorms affect you? How?

6. How do you feel at the ocean? Any improvement in symptoms there?

7. Any reaction to moon phases?

8. Any dislike for a particular season (Spring, Fall, etc.), or seasonal worsening of symptoms?

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9. Any desire for open air (fresh air, open windows, bedroom window cracked, etc.)? How strong?

PERSPIRATION:

1. Circle one: Absent Mild Moderate Heavy

2. In what particular areas do you perspire?
   Head Back Chest Groin Hands Feet

3. Any particular odor to the perspiration? Describe.

4. Any stains left on clothing or sheets? Describe>

ENERGY:

1. On average, where does your energy usually fall on the following scale (circle):

can hardly get out of bed					average			plenty each day	
1	2	3	4	5	6	7	8	9	10

2. What is your best time of day or night?

3. Worst time of day or night?

4. Does anything else modify your energy (make it better or worse)? Explain.

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5. On average, how is your motivation to do things you need and want to do each day (circle):

none		could be better				pretty good			excellent
1	2	3	4	5	6	7	8	9	10

SLEEP:

1. Any problems falling asleep at night? Describe.

2. Any problems staying asleep all night? Describe, and include if you usually wake at a certain time.

3. What is your preferred position to sleep in? Why?

4. Any position you cannot sleep in? Why not?

5. In your sleep, do you (circle):

snore talk grind teeth sweat drool move a lot

stick feet out of covers put arm(s) over/under your head

6. Do you wake refreshed in the morning?

7. How easy or difficult do you find it to wake up? How long does it take to feel fully awake most days?

8. Do you prefer to have covers on? Can you sleep without them in warm weather?

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9. Do you recall dreams? If so, relate any recurring or themes (even back in childhood). Also, please describe any recent dream, including any feeling you had in the dream.

PSYCHOSOCIAL HISTORY:

Please take your time with this section, and answer with as much honesty as possible. Using specific examples is most helpful. Use the back of the page or attach a page if needed.

1. What about others do you admire the most (or is there someone on particular you admire or have looked up to)? Why?

2. What about others annoys you or do you dislike? This could be a character trait, or something people do that really irks you.

3. How do you express your anger? What triggers it? How have you expressed it at your worst?

Name:_____ Date_____

4. When upset about something, do you prefer to be left alone, or to have someone available for talking/consolation?

5. How do you respond to music? How intense is your response?

6. How much do like or desire to travel?

7. How important is someone else's opinion of you (what others think of you)?

8. Briefly describe your relationship with your father (now and/or in the past):

9. Briefly describe your relationship with your mother (now and/or in the past):

10. Briefly describe any other significant relationships or life circumstances that affect you now (and/or have affected you in the past):

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11. Briefly describe your spiritual/religious beliefs:

12. Have you ever dealt with any addiction issues (personally, or with family members)? What addiction?

13. Describe your nature when you were a child? What were you like? What affected you?

14. If you feel this applies to your health, complete the following sentence: “I have never been well since…”:

15. Is there anything else that you feel affects your health now?

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FEARS: Circle any of the following common fears that you currently have, or had as a child:

Dark	Storms	Ghosts	Being alone
Basements	Dogs	Cats	Snakes
Spiders	Birds	Mice/rats	Other animals
Doctors	Dentist	Needles	Blood
Health issues in general	Cancer	Heart Disease	Germs
Death	Others dying (family)	Accidents	Robbers
Poverty	Failure	Public speaking	Taking tests
Heights	Narrow places (claustrophobia)	Water	Crowds
Bridges	Airplanes	Insanity	Vague sense of foreboding

Please list any other fears:

Do you have any particular worries that you don't consider fears? Be specific please.

REVIEW OF SYSTEMS

Please indicate whether you have any problems in the following areas (or had problems in the past). **Please write a brief description near any symptoms that are intense or a recurrent problem.**

1. HEAD:
____ Headaches
____ Migraines
____ Dandruff
____ Other:

2. EYES:
____ Blurry vision
____ Itchy eyes
____ Light sensitivity
____ Pain
____ Dryness
____ Redness
____ Other:

Name:_____ Date:_____

3. EARS:
____ Ringing
____ Infections
____ Hearing problems
____ Excess wax
____ Discharge
____ Itching
____ Other:

4. NOSE:
____ Sense of smell (acute, lost, altered?)
____ Sinus pain
____ Discharge
____ Stuffiness
____ Sneezing
____ Allergies
____ Bloody noses
____ Crusts inside
____ Other:

5. MOUTH/THROAT:
____ Sense of taste (altered, lacking, bad taste in mouth?)
____ Teeth (pain or other problems)
____ Tongue
____ Bleeding gums
____ Canker sores
____ Sore throats
____ Change in voice
____ Cold sores (herpes)
____ Bad breath
____ Trouble swallowing
____ Lump sensation in throat
____ Other:

6. NECK:
____ Sensitive to anything snug worn at neck
____ Thyroid issues
____ Neck pain
____ Stiffness
____ Other:

7. CHEST:
____ Chest pains
____ Heart palpitations
____ Shortness of breath
____ Wheezing
____ Cough
____ Breast tenderness
____ Breast lumps
____ Other:

8. ABDOMEN/GI:
____ Appetite
____ Heartburn/reflux
____ Belching
____ Nausea
____ Stomach pain
____ Bloating/distention
____ Abdominal pain
____ Ulcers
____ Constipation/difficult stool
____ Diarrhea
____ Flatulence
____ Hemorrhoids
____ Change in stool (color, consistency, shape, etc.)
____ Sensitive to anything snug worn around waist
____ Other:

Name:_____ Date:_____

9. GU/**FEMALE**:
____ Heavy menstruation
____ Painful menstruation
____ PMS
____ Vaginal discharge
____ History of STD's
____ Menopause/Perimenopause
____ Sex drive (libido)
____ Fertility issues
____ How old were you at your first period?
____ How old at menopause?
____ Number of pregnancies
____ Number of miscarriages
____ Other problems that would get worse around periods:
____ Other problems with periods:
____ Urinary tract/bladder infections
____ Blood in urine
____ Urinary incontinence
____ How many times do you urinate in the night?

10. GU/**MALE**:
____ Trouble urinating (starting, force of stream, incomplete emptying, etc.)
____ Incontinence
____ History of STD's
____ Prostate issues
____ Testicular pain or swelling
____ Blood in urine
____ Erections
____ Sex drive (libido)
____ How many times do you urinate during the night?
____ Other:

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11. MUSCULOSKELETAL/EXTREMITIES:
____ Body stiffness
____ Joint pains
____ Muscle pain
____ Low back pain
____ Other back pain
____ Sciatica
____ Muscle cramps
____ Swelling/edema
____ Significant injury in the past
____ Other:

12. SKIN/INTEGUMENT:
____ Acne
____ Eczema
____ Psoriasis
____ Dry heels or soles of feet
____ Other Dry skin
____ Itchy skin
____ Easy bruising
____ Discoloration
____ Skin infections/boils/cellulitis
____ Moles, skin tags (circle which, or both)
____ Skin cancer
____ Nails (soft, slow growing, split, brittle, ridged? Circle any that apply)
____ Hangnails
____ Ingrown toenails
____ Toenail fungus
____ Sensitivity to metals
____ Tendency to poison ivy
____ Hair falling out
____ Hair went gray early
____ Hair very dry/breaks/slow growing

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Physical Generals and Review of Systems

13. Neurologic:
____ Fainting or feeling faint
____ Seizures
____ Tremors
____ Balance problems
____ Numbness
____ Weakness
____ Tingling
____ Restless legs (awake or in bed)
____ Other:

14. MENTAL/EMOTIONAL:
____ Depression
____ Anxiety
____ Anger
____ Irritability
____ Mood changes
____ Concentration/focus
____ Memory
____ Confusion
____ Change in behavior
____ Other:

GENERAl:
____ Weight gain (unintended)
____ Weight loss (unintended)
____ Fever
____ Chills
____ Night sweats
____ Sleep problems
____ Fatigue
____ Anemia
____ Reaction to vaccination
____ Oversensitive to medications
____ Oversensitive to chemicals/odors
____ Other: