The Gleason Center
Your Personal Path to Health

Mr. Mrs. Miss Ms. (please circle one) Last Name: ____________________ First Name: ____________________________
Birthdate: ________________________ Today's Date: ________________________ Age: ________________
Address: ____ City: ________________ State: ________ Zip: _________________
Home Phone (____)__________________ Work Phone (_____)_________________ Cell Phone (_____)_________________
Email: ________________________________ Person Responsible for Account: ______________________________________
Medical Insurance Carrier: ____
Physician's Name: ______________________________________ Dentist's Name: ____________________________________
Occupation: ______________________________________Employer: ____
Who may we thank for referring you? ____
What is the **primary problem** you'd like Dr. Gleason to address? ____
____
____
When was the onset? ______________________________How often do you experience it? ___________________________
How long do symptoms last? ____
What treatments have you used? ____
____
List any **secondary problems**: ____
____
____

Indicate **approximate dates** of any of the following:

______ Heart Attack
______ High Blood Pressure
______ Low Blood Pressure
______ Diabetes
______ Varicose veins
______ Hepatitis
______ TB
______ Broken Bones
______ Orthopedic Surgery
______ Other Surgery
______ Auto Accident
______ Blow to Head
______ Blow to Jaw
______ Whiplash Injury
______ Serious Fall
______ Physical Therapy
______ Dentures
______ Bite Adjustment
______ Orthodontic Treatment
______ Periodontal Treatment
______ Teeth Sensitive
______ Difficulty Chewing

______ MS
______ Hypoglycemia
______ Ulcers
______ Constipation
______ Diarrhea
______ Heartburn or reflux
______ Poor Digestion
______ Stomach Gas
______ Gall Bladder Disorder
______ Hemorrhoids
______ Kidney Disorder
______ Frequent Urination
______ Urgent Urination
______ Urinary Dribbling
______ Cancer
______ Mononucleosis
______ Canker Sores
______ Fatigue
______ Anemia
______ Arthritis
______ Bursitis
______ Tendinitis

_____ Muscle Cramps
_____ Nervousness
_____ Vertigo
_____ Epilepsy
_____ Difficulty Sleeping
_____ Depression
_____ Psychotherapy
_____ Eye Pain/Pressure
_____ Eye Sensitivity to Light
_____ Sinus Trouble
_____ Headache _______ Location
_____ Migraine Headache
_____ Cold ________ Numb Hands
_____ Cold ________ Numb Feet
_____ Nosebleeds
_____ Swollen Feet or Ankles
_____ Pain ________ Stiff Shoulders
_____ Pain ________ Stiff Neck
_____ Pain ________ Stiff Mid Back
_____ Pain ________ Stiff Low Back
_____ Pain ________ Stiff Legs
_____ Acne

Women only:

______ Menstrual problems
______ Cramping
______ Post-partum Depression
______ Uterine Ablation
______ Miscarriage(s)

______ Excessive Flow
______ PMS
______ Menopause
______ Hot flashes
______ Number of pregnancies

_____ Clotting or dark flow
_____ Breast tenderness
_____ Hysterectomy
_____ Mood/memory problems
_____ Number of children

Have you recently experienced any of the following?

______ Death of a loved one
______ Divorce or separation
______ Illness or injury to family or friend
______ Marriage
______ Loss or change of job
______ Retirement
______ Pregnancy or birth of child
______ Sexual problems
______ Change in personal habits
______ Change in living conditions

Please elaborate on above: ____________________

____

Does your work/daily activity include any of the following?

______ Exposure to fumes
______ Exposure to chemicals
______ Mental stress
______ Physical stress
______ Sitting ______ Standing for long periods
______ Bending (Frequency: ______________)
______ Lifting (Weight: ______________)
______ Working overhead

What do you like about your job? ________________

____

Environmental allergies: ______________________

____

Rest, Elimination, Diet

Do you sleep on your
______ stomach ____ side ______ back

Hours of sleep per night: ______

Do you wake up ______ rested ______ tired

Bowel movements per day: _________

Describe BMs: ______________________________

Times you eat out per week: ________

Types of restaurants: __________________________

Typical breakfast: ____________________________

____

Typical lunch: _______________________________

____

Typical dinner: ______________________________

____

Snacks: ____________________________________

Time of day: _________________________________

Number of cups of coffee per day: ______________

Number of glasses of milk per day: _____________

Number of cans/bottles of pop per day: __________

Number of alcoholic drinks per day: _____________

Number of glasses of water per day: ____________

City water ______ Well water ______

Number of cigarettes per day: _________________

Food allergies: _______________________________

____

____

Physical Activity

What does your normal exercise program include?

Type of exercise: ______________________________
______ hours/day ______ days/week

Type of exercise: ______________________________
______ hours/day ______ days/week

Type of exercise: ______________________________
______ hours/day ______ days/week

Type of exercise: ______________________________
______ hours/day ______ days/week

Other: ______________________________________

____

List your medications/reasons for taking each:

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List your vitamin supplements: __________________

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For office use only: __________________________

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