The Gleason Center
Your Personal Path to Health

Last Name:_____ First Name:_____ Birth date:___/___/___ Age:_____

Please Circle: Male or Female Married: Yes No Partner's Name:_____

Additional Members of House Hold:_____

Address:_____City:_____ State:_____ Zip:_____

Cell Phone: _____ Home: _____Email:_____

Guardian/Responsible Party:_____ Medical Insurance Carrier:_____

Primary Physician:_____ Dentist:_____

Employer:_____ Occupation:_____

Who May We Thank For Referring You?_____

Main Issues/Concerns? When Did This Start? How Often? How Long Does It Last? Treatments Used/Tried?

1st_____

2nd_____

3rd_____

4th_____

Indicate Approximate Dates of the Following:

_____Heart Attack
_____High Blood Pressure
_____Low Blood Pressure
_____Diabetes
_____Varicose Veins
_____Hepatitis
_____Acne
_____Broken Bones
_____Orthopedic Surgery
_____Auto Accident
_____Blow to Head
_____Whiplash Injury
_____Serious Fall
_____Nose Bleeds
_____Dentures
_____Bite Adjustment
_____Orthodontic Treatment
_____Periodontal Treatment
_____Sensitive Teeth
_____Difficulty Chewing

_____Root Canal
_____Hypoglycemia
_____Ulcers
_____Constipation
_____Diarrhea
_____Heartburn
_____Poor Digestion
_____Stomach Gas
_____Gall Bladder
_____Hemorrhoids
_____Kidney Issues
_____Frequent Urination
_____Urgent Urination
_____Cancer
_____Mononucleosis
_____Canker Sore
_____Fatigue
_____Anemia
_____Arthritis /Bursitis
_____Tendinitis

_____Muscle Cramps
_____Nervousness
_____Vertigo
_____Epilepsy
_____Difficulty Sleeping
_____Depression
_____Psychotherapy
_____Eye Pain/Pressure
_____Sensitivity to Light
_____Sinus Trouble
_____ MS

Headaches:
Location:_____
_____Migraines
_____Tension
_____Sinus
_____ Stress
_____Cluster
_____TMJ

_____ Cold Hands or Feet (please circle one)
_____Numb Hands or Feet (please circle one)
_____Nerve Pain; Location:_____
_____Swollen Feet or Ankles

Pain or Stiffness:
_____Shoulders
_____Neck
_____Mid Back
_____Low Back
_____Other, Explain:_____

Women Only:

_____Menstrual Problems
_____Mood/Memory Issues
_____Post-Partum Depression
_____Age at 1st Menses
_____Number of Miscarriage(s)

_____ Excessive Flow
_____Breast Tenderness
_____Hysterectomy
_____Number of Pregnancies

_____Clotting or Dark Flow
_____Menopause
_____Uterine Ablation
_____Number Of Children

_____Cramping
_____Hot Flashes
_____PMS

Have You Experienced Any Of The Following?

Please Indicate Approximate Dates:

_____Death of a Loved One

_____Illness or Injury of 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:_____

_____

Work and Daily Life:

_____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:

How Do You Sleep?

_____Stomach _____Side L or R _____Back

Hours per night:_____ Third Shift:_____

Do you wake up: _____Rested _____Tired

Problems: Falling Asleep_____ Staying Asleep_____

Elimination:

Bowel Movements Per Day:_____

BM's: Hard___ Soft___ Loose___ Watery___ Normal___

Other:_____

For Office Use Only:

_____

_____

_____

_____

_____

_____

_____

_____

Diet:

Typical Breakfast:_____

Typical Lunch:_____

Typical Dinner:_____

Snacks:_____ Time of Day_____

Times You Eat Out Per Week:_____

Type of Restaurants:_____

Number of Cups Per Day: Water_____ Coffee _____
Milk _____Pop_____ Alcohol_____

City Water:_____ Well Water:_____

Number of Cigarettes Per Day:_____

Known Food Allergies:_____

_____

Physical Activity:

What Does Your Normal Exercise Program Include?

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Type of Exercise:_____

Hours Per Day:_____ Days Per Week:_____

Date of Last Physical:_____

Date of Last Dental Exam:_____

Vaccine History:_____

_____

_____

_____

_____

List Your Medications and Reasons for Taking:

_____

_____

_____

_____

_____

_____

_____

List Your Vitamin Supplements:

_____

_____

_____

_____

_____

_____

_____

_____