holistic einstein

105 Tenpenny St
Freeport, ME 04032

219 Mill St.
Rockport, ME 04856

Name:_____ Date of Birth:_____

Main Health Concerns Today:

1._____ 3._____

2._____ 4._____

For your most pressing health concern, please describe:

Your current symptoms, with as much detail as possible:

How this affects your life:

What makes this better or worse (medications, activities, therapies, supplements)

What testing or evaluations have been done:

What treatments you have tried for this problem, and how it worked:

y/n

Review of Symptoms Check of any of these symptoms you have had in the last 2 weeks.

GENERAL:

☐ weight gain ☐ weight loss ☐ tired/weak ☐ dizzy/fainting ☐ fever/chills ☐ night sweats

HEAD:

☐ headaches ☐ head trauma ☐ hearing loss ☐ noise in ears ☐ earaches
☐ eye pain ☐ vision loss ☐ itchy eyes ☐ eye discharge ☐ blurry vision
☐ cataracts ☐ painful teeth ☐ dentures ☐ bleeding gums ☐ runny/ stuffy nose
☐ nosebleeds ☐ sore throat ☐ swollen glands ☐ voice change ☐ room spins
☐ hearing aids ☐ wear glasses/contacts

RESPIRATORY:

☐ cough (w/phlegm? w/blood?) ☐ wheezing ☐ short of breath ☐ other trouble breathing

HEART & CIRCLATION:

☐ chest pain ☐ heart races or skips beats ☐ short of breath after climbing steps
☐ high blood pressure ☐ legs swell ☐ short of breath while lying in bed
☐ varicose veins ☐ heart murmur ☐ legs hurt or cramp when walking
☐ dizzy when standing up ☐easy bruising/bleeding

DIGESTIVE:

☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ indigestion ☐ nausea
☐ vomiting (w/ blood?) ☐ diarrhea ☐ constipation ☐ change in stool size or color
☐ blood in stool ☐ hemorrhoids ☐ rectal pain ☐ excess belching or passing gas
☐ 5+ bowel movements daily ☐ less than 3 bowel movements weekly ☐ undigested food in stool

URINARY:

☐ burning with urination ☐ frequent urination ☐ slow/weak urine stream ☐ blood in urine
☐ accidentally lose urine ☐ kidney stones ☐ up multiple times at night to urinate
☐ frequent urinary infection

MUSCULOSKELETAL:

☐ pain in muscles ☐ pain in joints ☐ swollen joints ☐ redness around joints ☐ arthritis
☐ morning stiffness ☐ back pain ☐ gout ☐muscle spasms ☐ scoliosis

NEUROLOGICAL:

☐ blackouts ☐ seizures ☐ numbness or loss of sensation (where?)
☐ tingling or "pins and needles" (where?) ☐ tremors or other involuntary movements
☐ weakness (where?) ☐ trouble with balance/unsteadiness

SKIN:

☐ rash ☐ hair loss ☐ itching ☐ skin pain ☐ moles ☐ sores ☐ nail changes (specify:)

ENDOCRINE:

☐ heat or cold intolerance ☐ cold hands or feet ☐ excessive thirst/hunger ☐excessive urination

PSYCHIATRIC

☐ nervousness ☐ anxiety ☐depression ☐ difficulty with memory ☐ hallucinations

MALE PATIENTS:

☐ lumps or pain in testicles ☐ erection problems ☐ discharge from penis Birth control method:

FEMALE PATIENTS:

☐ heavy bleeding ☐ painful periods ☐PMS ☐ painful intercourse ☐ vaginal sores or discharge
☐ breast lumps ☐ nipple discharge ☐ breast tenderness or pain ☐ hot flashes

Age your periods began: Number of days period lasts: Date of last period:
Number of pregnancies: Number of live births: Age at menopause:
Birth control method: