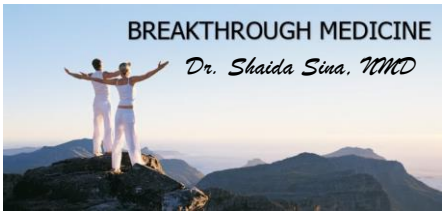


Patient Visit Location: 702 Main Street
Cottonwood, AZ 86326
928-649-0269
Fax: 866-644-6363

Return Visit Update

Last name: _____ First: _____ Middle: _____

Address: _____ Phone#: _____

Occupation: Employer: Employer Ph#:

List reason for visit: (e.g. chest cold, pain, prescription renewal, lab review, drug side effect, detox inquiry, specialist referral needed, annual checkup, etc. Please place in order of importance.

1.	2.
3.	4.
5.	6.

Please list prescriptions you may need refilled (by name):

List all Labs, Reports, Bloodwork, Thermal, Mammograms, Bone Density, X-Rays, Hair Analysis, Stool Testing, etc.

Changes in your health since your last visit? Yes / No. If "Yes" please explain below: Major life change (divorce, death in family, new job, etc.)

1.	2.
3.	4.
5.	6.
7.	8.

Have you see another medical provider, had a medical procedure, gone to urgent care, the emergency room or been hospitalized since our last visit? _____ If yes list provider's name, medical facility, and reason?

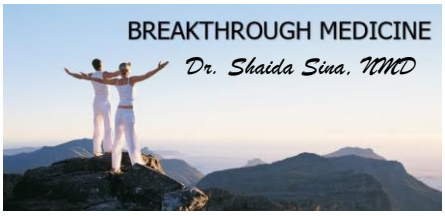
1.	2.
3.	4.

Please list all current medications dosages, and how you are taking your medication. Please note any changes since your last visit such as side effects and having to stop medication or reducing dose.

1.	2.
3.	4.
5.	6.

List what you're really taking in supplements, doses, and how you are taking (such as once daily, twice daily or at bedtime:

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.



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HEALTH PROFILE

NAME _____ DATE_____

Rate each of the following symptoms upon your typical health profile for:

Point Scale

0 *Never* or *Almost never* have the symptom
1 *Occasionally* have it, effect is *not severe*
2 *Occasionally* have it, effect is *severe*
3 *Frequently* have it, effect is *not severe*
4 *Frequently* have it, effect is *severe*

Head
____ Headaches
____ Faintness
____ Dizziness
____ Insomnia
____ TOTAL

Eyes
____ Watery or itchy eyes
____ Swollen, reddened or sticky eyelids
____ Bags or dark circles under eyes
____ Unusual blurred or tunnel vision
____ TOTAL

Ears
____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears, hearing loss
____ TOTAL

Nose
____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucous formation
____ TOTAL

Mouth Throat
____ Chronic coughing
____ Gagging, freq. Need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums, lips
____ Canker sores
____ TOTAL

Skin
____ Acne
____ Hives, rashes, dry skin
____ Hair loss
____ Flushing, hot flashes
____ Excessive sweating
____ TOTAL

Heart
____ Irregular or skipped heart beat
____ Rapid or pounding heartbeat
____ Chest pain
____ TOTAL

Lungs
____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing
____ TOTAL

Digestive Tract
____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal / stomach pain
____ TOTAL

Joints/ Muscles
____ Pain or aches in joints
____ Arthritis
____ Stiffness /limitation of movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness
____ TOTAL

Weight
____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight
____ TOTAL

Energy/ Activity
____ Fatigue, sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness
____ TOTAL

Mind
____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty in making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities
____ TOTAL

Emotions
____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression
____ TOTAL

Other
____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge
____ TOTAL

HEALTH PROFILE GRAND TOTAL _____

FEMALE HORMONE SURVEY

Please score: BLANK= No Symptoms.
USE 1-5 (1=Mild 5=Severe)

Hot Flashes	_____
Night Sweats	_____
Irritability	_____
Mood Swings	_____
Weepy	_____
Irregular Periods	_____
Heavy Periods	_____
Bleeding between periods	_____
Low sex drive	_____
Lumpy breasts	_____
Unable to reach orgasm	_____
Painful intercourse	_____
Lack of vaginal lubrication	_____
Breast tenderness	_____
Drooping breasts	_____
Sleep problems	_____
Anxiety or panic attacks	_____
Depression	_____
Loss of motivation	_____
Feeling apathetic	_____
Fatigue	_____
Memory loss	_____
Thinning hair	_____
Dry skin	_____
Cellulite	_____
Decreased muscle strength	_____
Fluid retention	_____
Headache	_____
Joint pain	_____
Muscle pain	_____
Urinary incontinence	_____
Acne	_____
Facial hair growth	_____
Constipation	_____
Food Cravings	_____
Vaginal Discharge	_____
Vaginal Itching	_____

HORMONE SURVEY TOTAL

_____