

BIG SKY INTEGRATIVE HEALTH, PLLC
8707 N. Jackrabbit Ln. Ste. A
Belgrade, MT 59714
(406) 388-6676

Name _____ Date _____

Age _____ Date of Birth ____ / ____ / ____ Gender: female ____ male ____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home) _____ (work) _____

Occupation _____ Hours per week _____ Retired ____

Employer _____ S.S.# _____

(Work address) _____

Married ____ Separated ____ Divorced ____ Widowed ____ Single _____

Partnership _____

Live with: Spouse ____ Partner _____ Parents _____ Children _____

Friends ____ Alone _____

Which doctor referred you? _____

How did you hear about us? _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

What are your most important health problems that your doctor is treating you for? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Current Medications

Do you take or use?

| | | | | | | | | |
|---------------|---|---|-----------------------|---|---|----------------|---|---|
| Laxatives | Y | N | Pain relievers | Y | N | Antacids | Y | N |
| Cortisone | Y | N | Appetite suppressants | Y | N | Tobacco | Y | N |
| Tranquilizers | Y | N | Thyroid medication | Y | N | Sleeping pills | Y | N |

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs.
Maximum Weight _____ When _____
Height _____
When during the day is your energy the best? _____ worst? _____

REVIEW OF SYSTEMS

Y= current condition N= never had P= past condition

FOR THE FOLLOWING, PLEASE CIRCLE

MENTAL/EMOTIONAL

| | | | | | | | |
|---------------------|---|---|---|-------------------------|---|---|---|
| Mood Swings? | Y | N | P | Anxiety or nervousness? | Y | N | P |
| Poor concentration? | Y | N | P | Memory problems? | Y | N | P |

ENDOCRINE

| | | | | | | | |
|---------------|---|---|---|---------------------------|---|---|---|
| Hypothyroid? | Y | N | P | Heat or cold intolerance? | Y | N | P |
| Hypoglycemia? | Y | N | P | Diabetes? | Y | N | P |
| Fatigue? | Y | N | P | Seasonal depression? | Y | N | P |

IMMUNE

| | | | | | | | |
|-----------------------------|---|---|---|----------------------------|---|---|---|
| Vaccinations? | Y | N | P | Reactions to vaccinations? | Y | N | P |
| Chronic Fatigue Syndrome? | Y | N | P | Chronic infections? | Y | N | P |
| Chronically swollen glands? | Y | N | P | Slow wound healing? | Y | N | P |

SKIN

| | | | | | | | |
|--------------|---|---|---|----------------|---|---|---|
| Rashes? | Y | N | P | Eczema, Hives? | Y | N | P |
| Acne, Boils? | Y | N | P | Itching? | Y | N | P |

HEAD

| | | | | | | | |
|--------------|---|---|---|------------|---|---|---|
| Headaches? | Y | N | P | Migraines? | Y | N | P |
| Head injury? | Y | N | P | | | | |

EARS

| | | | | | | | |
|------------|---|---|---|-------------------|---|---|---|
| Earaches? | Y | N | P | Impaired hearing? | Y | N | P |
| Dizziness? | Y | N | P | ringing? | Y | N | P |

NOSE AND SINUSES

| | | | | | | | |
|-----------------|---|---|---|----------------|---|---|---|
| Frequent colds? | Y | N | P | Nose Bleeds? | Y | N | P |
| Stiffness? | Y | N | P | Hayfever? | Y | N | P |
| Sinus problems? | Y | N | P | Loss of smell? | Y | N | P |

MOUTH AND THROAT

| | | | | | | | |
|-----------------------|---|---|---|-------------------|---|---|---|
| Frequent sore throat? | Y | N | P | Sore tongue/lips? | Y | N | P |
|-----------------------|---|---|---|-------------------|---|---|---|

RESPIRATORY

| | | | | | | | |
|---------|---|---|---|-------------|---|---|---|
| Cough? | Y | N | P | Wheezing? | Y | N | P |
| Asthma? | Y | N | P | Bronchitis? | Y | N | P |

CARDIOVASCULAR

| | | | | | | | |
|--------------------------|---|---|---|--------------------------|---|---|---|
| Heart disease? | Y | N | P | High/Low Blood Pressure? | Y | N | P |
| Palpitations/Fluttering? | Y | N | P | | | | |

GASTROINTESTINAL

| | | | | | | | |
|-------------------|---|---|---|--------------------------|---|---|---|
| Heartburn? | Y | N | P | Belching or passing gas? | Y | N | P |
| Change in thirst? | Y | N | P | Change in appetite? | Y | N | P |
| Bowel Movements | | | | Constipation? | Y | N | P |

How often? _____ Diarrhea? Y N P
 Is this a change? _____

URINARY

Increased frequency? Y N P Frequency at night? Y N P
 Frequent infections? Y N P

MUSCULOSKELETAL

Joint pain or stiffness? Y N P Arthritis? Y N P
 Muscle spasms or cramps? Y N P

HABITS

Do you exercise? Y N
 If yes, what kind? _____ How often? _____

| | | | |
|---------------------------------|-------|--------------------------|-------|
| Average 6-8 hrs. sleep? | Y N | Enjoy your work? | Y N |
| Sleep well | Y N | Take vacations? | Y N |
| Awaken rested? | Y N | Spend time outside? | Y N |
| Have a supportive relationship? | Y N | Watch television? | Y N |
| Any major traumas? | Y N | how many hours? _____ | |
| Have a history of abuse? | Y N | Read? | Y N |
| Use recreational drugs? | Y N P | how many hours? _____ | |
| Treated for drug dependence? | Y N P | | |
| Do you eat 3 meals a day? | Y N P | Use alcoholic beverages? | Y N P |
| Do you eat out often? | Y N P | Treated for alcoholism? | Y N P |
| Do you go on diets often? | Y N P | Do you use tobacco? | Y N P |
| Do you drink coffee? | Y N P | | |
| Do you drink black tea? | Y N P | | |
| Do you drink cola? | Y N P | | |
| Do you eat refined sugar? | Y N P | | |
| Do you add salt? | Y N P | | |

Is there any information about your health you would like to add?

Welcome! I'm happy to help you! If you have any questions, just ask!