Tree of Life Integrative Medicine 826 Camino De Monte Rey suite B2 Santa Fe, NM 87505
Dr. Acazia Gilmore 505-670-3396
Dr. Eric Brunn 505-699-0660

Reason For Visit

Primary reason for visit:_____

When did your first notice it?_____What brought it on? _____

Describe any stressors occurring at the time_____

What activities provide relief?_____what makes it worse? _____

Is this condition getting worse?_____interfere with work_____sleep_____ recreation_____

Have you had massage/bodywork before?_____ What type? _____

Medical History

Are you currently under the care of another health care provider(s)?_____Reason (s)_____

_____
_____

Name(s) of Practitioner_____Address:_____
____

Phone_____email_____
_____

Current Medications and /orSupplements/
Remedies:_____

_____
_____

Allergies: specify allergen and
reaction:_____

Surgical History (year and type) and/or Recent
Procedures:_____

_____
_____

Hospitalizations:
_____

Accidents or
Traumas_____
__

Falls/Injuries to Sacrum/head/tailbone
(describe)_____

Other:

Page 2. **Please review and check the following:**

Headaches Type:	Past Present	Numbness in feet or legs when standing	Past Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Family History

	Still Living?	Cause and Age of Death	Major Health Issues
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastroinstestinal Health History

Describe your typical:

Breakfast:_____

Lunch:_____

Dinner:_____

_

Snacks:_____Water Intake(glasses/ day)_____Caffeine_____

What is the worst item in your diet_____What foods are your weakness_____

Are you subject to binge eating?_____What foods_____

Do you experience bloating/gas/burps after eating?_____What foods trigger this?_____

Food Allergies?_____Describe_____

How often are your bowel movements?_____Do your stools: sink_____float_____

Constipation?_____Blood in stool ?_____Mucus in stool?_____Pain when stooling?_____

Diarrhea?_____Other?
_____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?
_____

Describe the most positive emotion you experience_____

When and Where do you experience this emotion?
_____

Describe the most negative emotion you experience_____

When and Where do you experience this emotion?
_____

Describe your Spiritual and/or Religious practice:_____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Faith_____Hope____Charity____Generosity_____ Sense of Humor_____Fear_____Grief_____Sense of Fun_____

What hobbies/ activities provide you with pleasure and accomplishment
_____

Describe your exercise routine (type, frequency)_____

What changes would you like to achieve in 6 months:_____

One
Year:_____

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____ounces/ day

Marijuana?_____Quantity_____Other:_____ Have you been under treatment for substance use?

Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other:_____Length of time using method_____Last Pap smear____Results _____

Are now or in the past experiencing Fertility Challenges? Yes___No___Describe your treatment :_____

(IUI, IVF,etc)_____

Menstrual History Review and check as indicated:

Age of Menses:_____What was this like for you? _____

Last Menstrual Period:_____Length of Menses_____

Are you trying to Conceive? Yes_____No_____ Are you Pregnant? Yes____No____Unsure____

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	

Episodes of Amenorrhea How long?			

Rate your interest in Sex:
High_____Moderate_____Low_____None_____

Do you have or ever had difficulty experiencing orgasms_____

Have you experienced trauma?
Yes___No____Describe_____

Did you undergo counseling for this_____

What was this like for you_____

Pregnancy History

Number of Pregnancies:_____Dates_____Miscarriage(s)_____Dates_____Termination(s)_____Dates:_____

Number of Births:_____
Dates:_____

Complications for any of the above, describe:_____

Premature Births?_____ Spotting During Pregnancy? _____Weak Newborns? _____Incompetent Cervix? _____

Describe your experience with:

Pregnancy:_____

Labor:_____

Birthing_____

Post Partum:_____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis------PMS Menopause

Cancer(type)_____Menstrual Problems _____
Other_____

Medications your mother took when she was pregnant with you (if any)_____

Your Birth Trauma (if known)
_____

Menopause

Age symptoms began:_____Are they getting worse_____better_____same_____

Are you on/ or ever been on hormone replacement therapy?_____if so, how long_____

Name and dose_____

Reason for stopping_____

Age of Mother at menopause:_____Concerns/
Experience_____

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here:

Male Reproductive Health History

Please check the symptoms below that apply

Painful Urination	Past Present	Urinary Retention	Past Present
Urinary Incontinence or Dribbling		Difficult starting or holding urine stream	
Weak or Interrupted Urine flow		Blood or pus in urine	
Pain or Burning with Urination		Pelvic pressure	
Nocturnal Urination How many times?		Insatiable sex drive	
Pain in lower back, esp After intercourse		Pain or Discomfort Between scrotum and Testicles	
Pain or Discomfort in: Penis Testicles Rectum		Pain or Discomfort in Inner thighs: Left Right Both	
Frequent Bladder or Kidney Infections When?		Erection: Difficulty in Obtaining Maintaining Painful ejaculation	

Results of PSA (prostate specific antigen) Test if known_____ Date done_____

Results of Sperm count (if applicable and known)_____Date done_____

Family History of Prostate Disease:
Yes___No___Type_____Relationship_____

Family History of Cancer
Yes____No_____Type_____Relationship_____

Sexually transmitted disease Yes___ No___ Type if Known_____

Rate your interest in Sex:
High_____Moderate_____Low_____None_____

Do you have a history of trauma: describe
_____

Did you undergo counseling for this _____

What was this like for you _____

AAdditional Comments: