THE

iBODY

956 Huntington Drive
San Marino, CA 91108
Phone: 626.593.5993

Patient Name:____ DOB: __________________

Reason for Office Visit: ____

____

List of medications/dose you are taking, including over the counter drugs and supplements:

____
____
____
____

Allergies: ____

Past Medical History (circle all that apply):

Anemia, Arthritis, Asthma, Autoimmune, Cancer, Chemical Sensitivity, Chronic Fatigue Syndrome, Chronic Pain, Depression, Diabetes, Elevated Cholesterol, Fibromyalgia, Gall Stones, Hay Fever, Heart Disease, Hepatitis, Hypertension, Irritable Bowel Syndrome, Kidney Disease, Liver Disease, Migraine Headache, Osteoporosis, Reflux, Stroke, Thyroid Disease, Ulcer

Other Diseases: ____

Surgery or Hospitalization/Dates: ____

____

Current or Recent Past Symptoms (circle all that apply):

Anxiety, Back Pain, Bladder Infection, Bloating, Blurred Vision, Bowel Change, Constipation, Cough, Chest Pain, Diarrhea, Dizziness, Ear Ache, Fatigue, Fever, Forgetfulness, Hay Fever, Headache, Head Trauma, Hemorrhoid, Indigestion, Joint Pain, Loss of Sleep, Mood Swings, Muscle Weakness, Nausea , Neck Pain, Nervousness, Palpitation, Rash, Rectal Bleeding, Shortness of Breath, Sinus Problems, Swelling Ankles, Stomach Pain, Vaginal Infection, Vomiting, Weight Change

Other Symptoms: ____

I Would Like To (circle all that apply):

Be Free of Pain, Be More Relaxed, Burn More Body Fat, Create a Wellness Lifestyle, Feel More Vital, Get Less Colds and Flu, Get Rid of Allergies, Have More Energy, Have More Muscle Tone, Improve Memory, Improve Sex Drive, Lose Weight, Not Dependent of Medication, Reduce My Risk of Degenerative Disease, Sleep Better, Slow Down Aging Process, Think More Clearly

Other:____

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What is your occupation? ____

On average, how many hours do you work per day? ____

Stress Level: ____ Low ____Moderate ____High

My diet is ___healthy ___can be better.

What types of food do you typically eat for:

(1) Breakfast:____

(2) Lunch: ____

(3) Dinner: ____

(4) Snack: ____

Do you drink alcohol? ___No ___Yes

If yes, I drink: ___Never ___Socially ___Heavily

If you chose 'heavily', on average how many drinks do you have a day? ______________________

How much caffeine do you drink per day? ______________________

Are you a smoker? ___No ___Yes

If yes, how many packs/cigarettes do you smoke a day? _________________

How long have you been a smoker? ________________________________

How many days do you exercise a week (circle one)? 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7

What type of exercise do you normally do? ____

Do you have any other questions for me or comments you would like to share?

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____

____

Patient Signature Date