HALLOWITZ HOLISTIC HEALING, P.S. TOBY K. HALLOWITZ, ND, MSOM, EAMP

101 N. Evergreen Rd., Spokane Valley, WA 99216 Ph: 509.228.3528 Fax: 509.464.6371 www.dr-toby.com

Please Print (Last) (Middle) (First)

Natural healing is possible only when the doctor completely understands the patient's physical, mental and emotional condition. The information you provide helps him understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything you have a question about.

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Address _____
STREET OR POB

_____
CITY, STATE, ZIP

Phone _____
HOME

_____
WORK WITH EXTENSION

SSN _____

Date of birth _____ Age _____ ❑ Female ❑ Male

Emergency Contact _____

_____
PHONE NUMBER

_____
RELATIONSHIP

Occupation _____

How many children do you have? _____

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Other _____

With whom do you live? ❑ Spouse ❑ Friends ❑ Parents ❑ Alone ❑ Children ❑ Other _____

When did you last go to a doctor's office, medical clinic, or hospital? What was the reason?

_____

_____

_____

_____

_____

_____

_____

What are your most important health concerns?

_____

_____

_____

_____

_____

EMAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT US? _____

_____

SUMMER ADDRESS:

_____

_____

_____

SUMMER PHONE:

Signature _____
responsible party if patient is a minor

Please print name _____

Date _____

HOSPITALIZATION AND SURGERY

What hospitalization or surgeries have you had? _____

_____

_____

_____

_____

X-RAYS & SPECIAL STUDIES

What diagnostic imaging studies have you had?

- ❑ Electrocardiogram
- ❑ Electroencephalogram
- ❑ X-rays
- ❑ Mammogram
- ❑ CT scan
- ❑ MRI
- ❑ Bone Density Scan
- ❑ Other _____

_____

MEDICATIONS OR SUPPLEMENTS

List medications or supplements that you currently take.

_____

_____

_____

_____

_____

Please check (4) the box for any of the following that you currently take:

- ❑ Pain Relievers (Aspirin or Tylenol)
- ❑ Diet pills / Appetite suppressants
- ❑ Cortisone (cream or pills)
- ❑ Thyroid medication
- ❑ Sleeping pills
- ❑ Antacids (Rolaids or Tums)
- ❑ Laxatives
- ❑ Tranquilizer

ALLERGIES

Do you have allergies to food, drugs or other allergens in your environment (cats, mold, dust)? If yes, please explain.

❑ No ❑ Yes _____

_____

_____

_____

IMMUNIZATIONS

What immunizations have you had? Please place a (?) on the line if you do not know.

- ❑ ____ Diphtheria
- ❑ ____ Measles/Mumps/Rubella
- ❑ ____ Polio
- ❑ ____ Pertussis
- ❑ Tetanus shot (not antitoxin)
- ❑ Other _____

CHILDHOOD ILLNESSES

Have you had the following illnesses?	Yes	No
Scarlet Fever	❑	❑
Diphtheria	❑	❑
Rheumatic Fever	❑	❑
Mumps	❑	❑
Measles	❑	❑
German Measles	❑	❑

Other _____

SELF & FAMILY HISTORY

Father

Health ❑ Good ❑ Poor

Age (at death) _____

Cause of death _____

_____

Mother

Health ❑ Good ❑ Poor

Age (at death) _____

Cause of death _____

_____

SELF & FAMILY HISTORY continued…

Please check (✔) the box for any of the following that you or family members have experienced.

Cancer	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Diabetes	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Heart Disease	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
High Blood Pressure	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Stroke	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Epilepsy	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Mental Illness	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Asthma	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Hayfever, Hives	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Anemia	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Kidney Disease	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Liver Disease	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Gallbladder Disease	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Ulcer	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Tuberculosis	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Goiter	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Arthritis	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Heart Murmur	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Cataracts	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____
Glaucoma	❑ self	❑ father	❑ mother	❑ sister	❑ brother	❑ children	❑ _____

REVIEW OF SYSTEMS

Circle the response that applies:

Y = *a condition you have now* **P** = *a condition you have had in the past* **N** = *a condition you have never had*

GENERAL

Weight _____ Weight 1 year ago _____

Maximum weight _____

When _____ Height _____

Fatigue	Y	P	N

SKIN

Rashes	Y	P	N
Eczema, hives	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Lumps	Y	P	N
Night Sweats	Y	P	N

HEAD

Headache	Y	P	N
Head Injury	Y	P	N

EYES

Impaired vision	Y	P	N
Glasses or contacts	Y	P	N
Eye Pain	Y	P	N
Tearing or dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N

EARS

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N

NOSE and SINUSES

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Hay fever	Y	P	N
Sinus problems	Y	P	N

MOUTH and THROAT

Frequent sore throat	Y	P	N
Sore tongue	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N

NECK

Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N
Pain or stiffness	Y	P	N

RESPIRATORY

Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
At night	Y	P	N
Lying down	Y	P	N
Tuberculosis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N
Angina	Y	P	N
High blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest Pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitations, fluttering	Y	P	N

REVIEW OF SYSTEMS continued...Circle the response that applies.

Y = *a condition you have now*
P = *a condition you have had in the past*
N = *a condition you have never had*

GASTROINTESTINAL

Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Vomiting	Y	P	N
Vomiting blood	Y	P	N
Bowel movements			
How often? _____			
Is this a change? _____			
Blood in stool	Y	P	N
Belching or passing gas	Y	P	N
Jaundice (yellow skin)	Y	P	N
Liver disease	Y	P	N
Hemorrhoids	Y	P	N

URINARY

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N

FEMALE REPRODUCTIVE

Age mense began? _____
Average number of days? _____
Length of cycle? _____

Bleeding between periods	Y	P	N
Are cycles regular	Y	P	N
Pain during intercourse	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
Birth Control	❑ Yes	❑ No	

What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____

Difficulty conceiving	❑ Yes	❑ No	
Menopausal symptoms	Y	P	N
Are you sexually active?	❑ Yes	❑ No	
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Sexual preference	❑ Heterosexual		
	❑ Bisexual		
	❑ Homosexual		
Do you do self-exam?	Y	P	N
Lumps	Y	P	N
Pain or tenderness	Y	P	N
Nipple discharge	Y	P	N

MALE REPRODUCTIVE

Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Are you sexually active?	❑ Yes	❑ No	
Sexual difficulties	Y	P	N
Prostate disease	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N
Sexual preference	❑ Heterosexual		
	❑ Bisexual		
	❑ Homosexual		

MUSCULOSKELETAL

Joint pain or stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasms or cramps	Y	P	N
Weakness	Y	P	N

PERIPHERAL VASCULAR

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N
Thrombophlebitis	Y	P	N

NEUROLOGIC

Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness or tingling	Y	P	N
Loss of memory	Y	P	N

EMOTIONAL

Depression	Y	P	N
Mood Swings	Y	P	N
Anxiety or nervousness	Y	P	N
Tension	Y	P	N

ENDOCRINE

Hypothyroid	Y	P	N
Heat or cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N

BLOOD

Anemia	Y	P	N
Easy bleeding or bruising	Y	P	N

HABITS

What are your main interests and hobbies?

_____
_____
_____
_____

Do you exercise? ❑ Yes ❑ No

How many days per week? _____

What type of exercise do you do?

_____
_____
_____
_____

Eat three meals daily?	❑ Yes	❑ No
Awaken rested?	❑ Yes	❑ No
Sleep well?	❑ Yes	❑ No
Avg. 6--8 hours sleep?	❑ Yes	❑ No
Enjoy your work?	❑ Yes	❑ No
Spend time outside?	❑ Yes	❑ No
Take vacations?	❑ Yes	❑ No
Watch television?	❑ Yes	❑ No

How many hours per day? _____

Read? ❑ Yes ❑ No

How many hours per day? _____

Use recreational drugs?	❑ Yes	❑ No
Use tobacco?	❑ Yes	❑ No
Use alcoholic beverages?	❑ Yes	❑ No
Have you been treated for alcoholism?	❑ Yes	❑ No
Have you been treated for drug dependence?	❑ Yes	❑ No

Thank you!

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Name _____

Date _____