

**CUSTOMIZED PATIENT PROFILE (CPP)**

PATIENT FIRST NAME _____	LAST NAME _____	DATE OF BIRTH _____	PRACTITIONER'S NAME _____
E-MAIL ADDRESS _____	GENDER _____	FILE NUMBER- _____	

**HEALTH HISTORY PROFILE**

Mark the following if applicable: **P=personal history**  **F=family history**  **B=both personal & family**

<input type="checkbox"/> Acne <input type="checkbox"/> ADHD <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergic Rhinitis <input type="checkbox"/> Alopecia <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amenorrhea <input type="checkbox"/> Amyloidosis <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Angiodema <input type="checkbox"/> Anorexia Nervosa <input type="checkbox"/> Anxiety <input type="checkbox"/> Appendicitis <input type="checkbox"/> Asthma <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Benign Prostatic Hyperplasia <input type="checkbox"/> Bile Insufficiency <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia Nervosa <input type="checkbox"/> Burns <input type="checkbox"/> Bursitis <input type="checkbox"/> Cancer, Bone <input type="checkbox"/> Cancer, Brain <input type="checkbox"/> Cancer, Breast <input type="checkbox"/> Cancer, Colon <input type="checkbox"/> Cancer, Lung <input type="checkbox"/> Cancer, Prostrate <input type="checkbox"/> Cancer, Skin <input type="checkbox"/> Candidiasis <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Cataracts <input type="checkbox"/> Cellulitis <input type="checkbox"/> Cervical Dysplasia <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Cirrhosis of the Liver <input type="checkbox"/> Common Cold <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Constipation <input type="checkbox"/> Cough <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cutaneous Drug Reactions <input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Degenerative Disk Disease <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Dermatitis <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Diarrhea <input type="checkbox"/> Diverticular Disease <input type="checkbox"/> Dysbiosis <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Dysphagia <input type="checkbox"/> Eczema <input type="checkbox"/> Edema <input type="checkbox"/> Encephalitis, Viral <input type="checkbox"/> Endocarditis <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fainting <input type="checkbox"/> Fever of Unknown Origin <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Flu <input type="checkbox"/> Food Allergy <input type="checkbox"/> Food Poisoning <input type="checkbox"/> Frequent Cold and Flu <input type="checkbox"/> Frostbite <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Gastritis <input type="checkbox"/> Gastroesophageal Reflux Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Hair Disorders <input type="checkbox"/> Headache, Migraine <input type="checkbox"/> Headache, Sinus <input type="checkbox"/> Headache, Tension <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis, Viral <input type="checkbox"/> Herpes Simplex Virus <input type="checkbox"/> Herpes Zoster (Varicella-Zoster) Virus <input type="checkbox"/> Hirsutism <input type="checkbox"/> Histoplasmosis <input type="checkbox"/> HIV and AIDS <input type="checkbox"/> Hyperchlorhydria <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hyperparathyroidism <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Hypochlorhydria <input type="checkbox"/> Hypochondriasis <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypoparathyroidism <input type="checkbox"/> Hypothermia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Infantile Colic <input type="checkbox"/> Insects Bites and Stings <input type="checkbox"/> Insomnia <input type="checkbox"/> Intestinal Parasites <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Laryngitis <input type="checkbox"/> Leaky Gut Syndrome <input type="checkbox"/> Leukemia <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Lymphoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Measles <input type="checkbox"/> Meningitis <input type="checkbox"/> Menopause <input type="checkbox"/> Metabolic Syndrome <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Motion Sickness <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Myeloproliferative Disorders <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Nail Disorders <input type="checkbox"/> Neuralgias <input type="checkbox"/> Neuritis <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Otitis Media <input type="checkbox"/> Pancreatic Insufficiency <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Pericarditis <input type="checkbox"/> Perimenopause <input type="checkbox"/> Peritonitis <input type="checkbox"/> Pertussis	<input type="checkbox"/> Pharyngitis <input type="checkbox"/> PMS <input type="checkbox"/> Post Traumatic Stress Disorder <input type="checkbox"/> Preeclampsia <input type="checkbox"/> Primary Pulmonary Hypertension <input type="checkbox"/> Proctitis <input type="checkbox"/> Prostatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Pulmonary Edema <input type="checkbox"/> Pyloric Stenosis <input type="checkbox"/> Radiation Damage <input type="checkbox"/> Raynaud's Phenomenon <input type="checkbox"/> Reiter's Syndrome <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Roseola <input type="checkbox"/> Roundworms <input type="checkbox"/> Rubella <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Seizure Disorders <input type="checkbox"/> Serum Sickness <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Shock <input type="checkbox"/> Sinusitis <input type="checkbox"/> Skin Disorders--Erythema <input type="checkbox"/> Skin Disorders--Photodermatitis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Sprains and Strains <input type="checkbox"/> Stress <input type="checkbox"/> Stroke <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Temporomandibular Joint Dysfunction <input type="checkbox"/> Tendonitis <input type="checkbox"/> Thyroiditis <input type="checkbox"/> Transient Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Urethritis <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Urinary Tract Infection in Women <input type="checkbox"/> Urolithiasis <input type="checkbox"/> Uveitis <input type="checkbox"/> Vaginitis <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Warts <input type="checkbox"/> Wounds
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**DRUG/SUPPLEMENT HISTORY**

Please list any and all drugs/medications which you are presently using or have used in the past and why. Reflect carefully as your current healthstate may relate directly to the treatment of a past problem.



**Do you supplement your diet with vitamins or minerals? YES/NO**

Please list the brand name, content and potencies of all products used and indicate the frequency which they are taken. Also indicate who prescribed these supplements for you and how he/she determined your specific needs and dosages.

**STRUCTURAL**

Mark the following if applicable: **C**=currently experiencing  **P**=experienced in past  **B**=Both current and past

<b>Head</b> <input type="checkbox"/> Myogenic Headaches <input type="checkbox"/> Vertebrogenic Headaches <input type="checkbox"/> Migraine Headaches with Aura <input type="checkbox"/> Migraine Headaches without Aura	<b>Elbow</b> <input type="checkbox"/> Lateral Epicondylitis <input type="checkbox"/> Medial Epicondylitis	<input type="checkbox"/> Lumbar Facet Syndrome <input type="checkbox"/> Lumbar Muscle Strain <input type="checkbox"/> Lumbar Spine Subluxation <input type="checkbox"/> Osteoarthritis in the Lumbar Spine	<input type="checkbox"/> Medial Collateral Sprain <input type="checkbox"/> Medial Meniscus Sprain/Tear <input type="checkbox"/> Patellar Tendonitis <input type="checkbox"/> Patellofemoral Pain Syndrome
<b>Neck</b> <input type="checkbox"/> Facet Irritation <input type="checkbox"/> Facet Syndrome <input type="checkbox"/> Osteoarthritis in the Cervical Spine <input type="checkbox"/> Postural Syndrome (Muscle Strain) <input type="checkbox"/> Cervical Spine Subluxation <input type="checkbox"/> Whiplash	<b>Wrist/Hand/Forearm</b> <input type="checkbox"/> Carpal Tunnel Syndrome	<b>Buttock</b> <input type="checkbox"/> Gluteus Medius/Minimus Syndrome <input type="checkbox"/> Ischial Bursitis <input type="checkbox"/> Piriformis Syndrome <input type="checkbox"/> Sacroiliac Irritation <input type="checkbox"/> Sacroiliac Syndrome <input type="checkbox"/> Sciatica	<b>Ankle</b> <input type="checkbox"/> Inversion Sprain
<b>Shoulder</b> <input type="checkbox"/> Adhesive Capsulitis <input type="checkbox"/> Impingement Syndrome <input type="checkbox"/> Rotator Cuff Tendonitis	<b>Mid Back</b> <input type="checkbox"/> Postural Syndrome (Muscle Strain) <input type="checkbox"/> Scoliosis <input type="checkbox"/> Thoracic Spine Facet Irritation <input type="checkbox"/> Thoracic Spine Subluxation	<b>Low Back</b> <input type="checkbox"/> Iliopsoas Muscle Strain <input type="checkbox"/> Lumbar Disk Herniation <input type="checkbox"/> Lumbar Facet Irritation	<b>Foot</b> <input type="checkbox"/> Hallux Valgus <input type="checkbox"/> Metatarsalgia <input type="checkbox"/> Pes Planus <input type="checkbox"/> Plantar Fasciitis
		<b>Knee</b> <input type="checkbox"/> Anterior Cruciate Sprain <input type="checkbox"/> Iliotibial Band Syndrome <input type="checkbox"/> Lateral Collateral Sprain	

**SPINAL**

\*Mark only if you know the specific problematic area

<b>Cervical Spine</b> <input type="checkbox"/> C0-C1 <input type="checkbox"/> C1-C2 <input type="checkbox"/> C2-C3 <input type="checkbox"/> C3-C4 <input type="checkbox"/> C4-C5 <input type="checkbox"/> C5-C6 <input type="checkbox"/> C6-C7 <input type="checkbox"/> C7-T1	<b>Thoracic Spine</b> <input type="checkbox"/> T1-T2 <input type="checkbox"/> T2-T3 <input type="checkbox"/> T3-T4 <input type="checkbox"/> T4-T5 <input type="checkbox"/> T5-T6 <input type="checkbox"/> T6-T7 <input type="checkbox"/> T7-T8 <input type="checkbox"/> T8-T9 <input type="checkbox"/> T9-T10 <input type="checkbox"/> T10-T11 <input type="checkbox"/> T11-T12 <input type="checkbox"/> T12-L1	<b>Lumbar Spine</b> <input type="checkbox"/> L1-L2 <input type="checkbox"/> L2-L3 <input type="checkbox"/> L3-L4 <input type="checkbox"/> L4-L5 <input type="checkbox"/> L5-S1
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**WELLNESS INFORMATION**

\*Check off any areas that interest or concern either you or a loved one.

<b>Fitness</b> <input type="checkbox"/> Exercise Reference <input type="checkbox"/> Fit Life <input type="checkbox"/> Sports and Activities <input type="checkbox"/> Sports Injuries <input type="checkbox"/> Sports Nutrition	<b>Women's Health</b> <input type="checkbox"/> Fertility and Pregnancy <input type="checkbox"/> Fitness and Nutrition <input type="checkbox"/> Illness and Prevention <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health <input type="checkbox"/> Sexual Health	<b>Children's and Teens' Health</b> <input type="checkbox"/> Babies and Toddlers <input type="checkbox"/> Illness and Prevention <input type="checkbox"/> Mental Health <input type="checkbox"/> School-age Children <input type="checkbox"/> Teen Health	<b>Nutrition</b> <input type="checkbox"/> Healthy Kitchen <input type="checkbox"/> Herb Reference <input type="checkbox"/> Illness and Prevention <input type="checkbox"/> Nutritional Health Encyclopedia <input type="checkbox"/> Supplement Reference
<b>Health at Work</b> <input type="checkbox"/> Stress Management <input type="checkbox"/> Travel and Commuting <input type="checkbox"/> Work Environment	<b>Men's Health</b> <input type="checkbox"/> Fitness and Nutrition <input type="checkbox"/> Illness and Prevention <input type="checkbox"/> Mental Health <input type="checkbox"/> Sexual Health	<b>Seniors' Health</b> <input type="checkbox"/> Fitness and Nutrition <input type="checkbox"/> Illness and Prevention <input type="checkbox"/> Mental Health <input type="checkbox"/> Sexual Health	<b>Mental Health</b> <input type="checkbox"/> Brain and Memory <input type="checkbox"/> Conditions and Disorders <input type="checkbox"/> Psychology and Behavior <input type="checkbox"/> Therapies

**ALLIED THERAPIES**

\*Check off any areas that interest or concern either you or a loved one.

<input type="checkbox"/> Acupuncture <input type="checkbox"/> Aromatherapy <input type="checkbox"/> Ayurveda <input type="checkbox"/> Biofeedback	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Clinical Nutrition <input type="checkbox"/> Herbal Medicine <input type="checkbox"/> Homeopathy <input type="checkbox"/> Hypnotherapy	<input type="checkbox"/> Massage Therapy <input type="checkbox"/> Mind/Body medicine <input type="checkbox"/> Naturopathy <input type="checkbox"/> Relaxation Techniques <input type="checkbox"/> Reflexology	<input type="checkbox"/> Spirituality <input type="checkbox"/> Tai Chi <input type="checkbox"/> Therapeutic Touch <input type="checkbox"/> Traditional Chinese Medicine <input type="checkbox"/> Yoga
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