

Jennifer Phillips, N.D.

5 West Chestnut Ave  
Merchantville, NJ 08109

660 Woodbury Glassboro Rd  
Sewell NJ 08080

Phone (856)488-7067

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Person to Contact in Case of Emergency

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How were you referred to Dr. Phillips? \_\_\_\_\_

What are you most important health problems? Please list in order of importance, so that the health problems you want to address first are listed first.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

Medications (List all prescription and non-prescription drugs, dosages and length of time you have been taking these medications):

---



---



---

Supplements (List all vitamins, minerals, herbs, etc. List amounts of each):

---



---



---

Name and phone number of primary care physician: \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_

Women: When was your last pap smear? \_\_\_\_\_ If you have ever had abnormal results please specify what and when: \_\_\_\_\_

**Your Health History** (Please check if you have this medical condition currently or have had in the past, and **give details**):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Skin disorder           |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Goiter                 | <input type="checkbox"/> Thyroid disorder        |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Venereal disease        |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Drug addiction          |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Hemorrhoids             |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Kidney disease (stones) |
| <input type="checkbox"/> Colitis         | <input type="checkbox"/> Liver disorder         | <input type="checkbox"/> Pancreatitis            |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Psychological disorder | <input type="checkbox"/> Herniated spinal disk   |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Gall stones             |
| <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Severe physical injury | <input type="checkbox"/> Intestinal parasites    |
| <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Multiple sclerosis     | <input type="checkbox"/> Autoimmune disorder     |

Females Only:

- |  |   |
|--|---|
| <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> Uterine Fibroids         |
| <input type="checkbox"/> Ovarian cysts       | <input type="checkbox"/> Cervical dysplasia       |
| <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Menstrual irregularities |

**Family Health History** (Please note any significant medical conditions, especially cancer, heart disease, diabetes, high blood pressure, allergies, asthma, autoimmune disease, psychological disorders, thyroid disorders):

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Children: \_\_\_\_\_

**Symptom Survey** (If these symptoms do not apply, then leave them blank. If the symptoms apply to you, then check with the following: “1” for mild, occasional symptoms; “2” for moderate, more frequent symptoms; “3” for severe, constant symptoms.)

**Chest**

- Persistent cough
- Coughing up mucous
- Spitting up blood
- Wheezing
- Difficulty breathing
- Pain on breathing
- Shortness of breath
- Chest pain on exertion

**Mouth and Throat**

- Sore throat
- Sore tongue
- Bleeding gums
- Gingivitis
- Thrush
- Enlarged tonsils
- Hoarseness

**Neurological**

- Fainting
- Seizures
- Paralysis
- Muscle weakness
- Numbness
- Tingling
- Memory loss
- Headaches

**Breasts**

- Do you self-exam?
- Lumps
- Pain or tenderness
- Nipple discharge

**Eyes**

- Impaired vision
- Eye pain
- Excessive tearing or dryness
- Double vision

**Ears**

- Impaired hearing
- Discharge from ear
- Ringing in ear
- Earaches
- Dizziness
- Excessive earwax

**Musculoskeletal**

- Joint pain/stiffness
- Bursitis
- Tendonitis
- Low back pain
- Muscle aches or cramps
- Bruising easily

**Urinary**

- Increased frequency
- Blood in urine
- Dark color of urine
- Pain during urination
- Incontinence

**Nose and Sinuses**

- Nose bleeds
- Nasal stuffiness
- Sinus infections
- Pain or tenderness in face
- Nasal discharge
- Post-nasal drip

**Neck**

- Lumps
- Swollen glands
- Goiter
- Pain or stiffness

**Skin**

- Psoriasis
- Lumps
- Color change
- Eczema
- Boils
- Rashes
- Hives
- Acne

**Males Only**

- Testicular Pain
- Enlarged prostate
- Penile discharge
- Penile sores
- Testicular lumps

**Carbohydrate Metabolism**

- Crave sweets
- Irritable if a meal is missed
- Feel tired or weak if a meal is missed
- Dizziness when standing suddenly
- Headache if meal is missed
- Feel tired an hour or so after eating
- Heart Palpitations
- Feel shaky at times
- Over-sensitive to sugar
- Mood swings
- Anxiety or nervousness
- All symptoms worse if a meal is missed
- Need coffee for energy
- Sudden sleepiness
- Irritability or quick temper
- Headaches relieved by eating
- Symptoms appear 1-2 hours after eating

**GI**

- Abdominal cramps
- Burping or gas
- Blood in stool
- Undigested food in stool
- Mucous in stool
- Nausea
- Vomiting
- Stomach bloating after eating
- Heartburn or indigestion
- Gassiness in upper abdomen
- Diarrhea
- Constipation
- Suspected food allergies
- Feeling of food sitting in stomach
- Fullness after small amount of food

How many bowl movements per day? \_\_\_\_

Have you traveled to another country and had an intestinal infection with diarrhea from drinking the water or eating the food? If yes, when: \_\_\_\_\_

Have you gone camping and had an intestinal infection with diarrhea from drinking the water from an untreated lake or river? If yes, when: \_\_\_\_\_

**Female Reproductive**

- Bleeding between periods
- Pain during intercourse
- Painful menses
- Heavy menstrual bleeding
- Vaginal discharge
- Vaginal itching or burning
- Menopause/Hot flashes
- PMS. If yes, describe

\_\_\_\_\_  
 Difficulty conceiving

Type of birth control: \_\_\_\_\_

**Endocrine**

- Depression
- Dry, flaky skin
- Fatigue
- Poor concentration
- Excessive coldness
- Difficulty losing weight
- Headaches
- Brittle nails that break easily
- Swelling around ankles
- Thinning hair

Hospitalization and Surgery (Date and type of illness/surgery):

---

---

Special Imaging Studies (Please list any CT scans, MRI, X-rays, EKG):

---

---

Do you experience acute or chronic stress Y N If yes, please describe:

---

---

Exercise: Please describe what type, duration, and how often you exercise:

---

---

Energy: On a scale of "1 to 10", "1" being the absolute lowest energy, while "10" being the absolute best energy, rate your general energy level: \_\_\_\_\_

Do you have energy fluctuations throughout the day? Y N

If yes, then at what times do you have the lowest energy? \_\_\_\_\_

Have you used tobacco in the past? Y N If yes, then for how long and how much? \_\_\_\_\_

Are you currently using tobacco? Y N If yes, how much? \_\_\_\_\_

Do you get enough sleep? Y N How many hours/night? \_\_\_\_\_

Do you have trouble falling asleep? Y N Do you awaken well rested? Y N

Do you wake in the night? Y N If yes, how often? \_\_\_\_\_

Approximately how many times have you taken antibiotics? \_\_\_\_\_

For each episode that you have taken antibiotics, approximately how many days did you take it for? \_\_\_\_\_

Have you at any time taken antibiotics for a prolonged period of time? Y N

If yes, please indicate the length of time: \_\_\_\_\_

Women: Have you ever experienced frequent vaginal yeast infections? Y N

If yes, how often does it occur? \_\_\_\_\_

Have you taken birth control pills in the past? Y N

If yes, when and length of time: \_\_\_\_\_

Have you taken prednisone or other cortisone-type drugs? Y N

If yes, when and length of time: \_\_\_\_\_

Have you had athlete's foot, ringworm, or other chronic fungal infection of the skin or nails? Y N

Do you get more than two colds a year?    Y    N  
When you get a “cold” does it take longer than 1 week for it to resolve?    Y    N  
Do you have any chronic infections? Y    N  
Frequent low-grade fevers?    Y    N  
Cold sores or fever blisters?    Y    N  
Have you ever had “Mono”? Y    N

Women:    At what age did you have your first period? \_\_\_\_\_  
              If you are not menstruating, when was your last period? \_\_\_\_\_  
              Do you have a regular menstrual cycle?    Y    N  
              How many days are in your cycle? \_\_\_\_\_  
              How many days does your period last? \_\_\_\_\_  
              How many times have you been pregnant? \_\_\_\_\_  
              How many times have you given birth? \_\_\_\_\_ Dates: \_\_\_\_\_  
              Were there any birthing complications?    Y    N  
              If yes, please describe: \_\_\_\_\_

Men and women: How many children do you have? \_\_\_\_\_  
Please list their names and ages: \_\_\_\_\_

**Dental History**

Do you have any root canals?    Y    N  
If yes, how many and when were they done? \_\_\_\_\_  
How many silver tooth fillings do you have? \_\_\_\_\_  
Are they relatively new or have they been there for many years? \_\_\_\_\_

Please list other practitioners of “natural medicine” that you have used  
(e.g. acupuncture, chiropractic, homeopaths, etc.) and when this was done:  
\_\_\_\_\_  
\_\_\_\_\_

# Food Record

Please list the foods that you typically eat for each meal. Make sure to include foods that are not eaten frequently. Please underline the foods that are eaten more frequently. For example, if you eat cereal almost every day for breakfast, but only have eggs once a week, then underline the cereal and make sure to include the eggs on the list.

Breakfast: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Lunch: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dinner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Snack: \_\_\_\_\_  
\_\_\_\_\_

Dessert: \_\_\_\_\_  
\_\_\_\_\_

For each food class, please indicate how often you eat it. Write down whatever is most appropriate, be it once a day, 4 times a week, 3 times a day, etc....

Meat (beef, chicken, steak, turkey, ham, pork, luncheon meats, burgers): \_\_\_\_\_

Dairy (milk, cheese, yogurt, ice cream): \_\_\_\_\_ Eggs: \_\_\_\_\_

Bread: \_\_\_\_\_ Beans: \_\_\_\_\_ Fruit: \_\_\_\_\_

Fish (including tuna): \_\_\_\_\_ Salads: \_\_\_\_\_ Vegetables: \_\_\_\_\_

Nuts and seeds (including peanut butter): \_\_\_\_\_ Rice: \_\_\_\_\_

Sweets (cookies, candy, cake, ice cream, etc.): \_\_\_\_\_ Cereal: \_\_\_\_\_

Pasta: \_\_\_\_\_ Tofu: \_\_\_\_\_

For the liquids, please list how many 8 ounce cups per day or week.

Water: \_\_\_\_\_ Juice: \_\_\_\_\_ Milk: \_\_\_\_\_

Coffee (regular or decaff): \_\_\_\_\_ Tea: \_\_\_\_\_

Alcohol: \_\_\_\_\_ Soda: \_\_\_\_\_ Other: \_\_\_\_\_