Jennifer Phillips, N.D.

5 West Chestnut Ave, Merchantville, NJ 08109

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. _____ 4. _____

2. _____ 5. _____

3. _____ 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**):

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

Females Only:
____ Endometriosis
____ Ovarian cysts
____ Fibrocystic breasts
____ Uterine Fibroids
____ Cervical dysplasia
____ 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

Musculoskelatal
____ 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: _____