



Biochemistry History Form – 2020

Date Completed: _____

Patient Name _____ Gender: M or F

If minor, Parent(s) Full Name: _____

Height: _____ Weight: _____

Pt Occupation: _____ Pt Birthdate: _____

Phone: _____ Is this?: Patient Parent

Email: _____ Is this?: Patient Parent

1. Education: (Last grade completed) _____

2. Significant birth events _____

3. Injuries _____

4. Pregnancies _____

5. Previous Medications (No longer taking) _____

6. Primary Diagnosis/es _____

7. Present Treatment Approach _____

8. Please describe your diet _____

9. What are some of your favorite foods? _____

10. Do you often get sleepy after meals? Yes _____ No _____

11. Sleep problems? _____

12. Did/Do you enjoy school? Yes _____ No _____

13. Typical grades in school: A B C D F

14. Favorite subjects _____

15. Difficult subjects _____

16. Tendency for Anger: High _____ Average _____ Low _____

17. Tendency for Anxiety: High _____ Average _____ Low _____

18. Hobbies? _____

Sports? _____

19. Do you experience depression? Often _____ Sometimes _____ Never _____

20. Pain threshold: High _____ Average _____ Low _____

21. Do you function well under stress? Yes _____ No _____

22. Are you competitive at sports? Very _____ Average _____ No _____

23. Did you continue to grow taller after age 16? Yes _____ No _____

24. Ever married? _____ Children? _____

If a female, how many times were you pregnant? _____

Please Circle the Symptoms or Traits that Apply to You

- good response to antihistamines
- calm demeanor with high inner tension
- self-motivated
- rumination about past events
- very strong willed
- competitive in sports
- sparse chest/leg/arm hair
- artistic or musical ability
- obsessions with negative thoughts
- tendency to be overweight
- denial of depression
- food or chemical sensitivities
- family history of high accomplishment
- dry eyes and mouth
- social isolation
- upper body, head or neck pain
- obsessive/compulsive tendencies
- tendency to be overweight
- history of perfectionism
- hyperactivity
- addictiveness
- high anxiety/ panic tendency
- seasonal allergies (ragweed, pollens)
- tendency to stay up very late
- severe depression
- joint pains
- sensitivity to bright lights
- sensitivity to loud noises
- morning nausea
- affinity for spicy and salty foods
- tendency to delay or skip breakfast
- very dry skin

- pale skin, inability to tan
- high irritability and temper
- extreme mood swings
- history of a reading disorder

Please Circle the Symptoms or Traits that Apply to You

- history of underachievement
- little or no dream recall
- autoimmune disorders
- "fruity" breath and/or body odor
- stretch marks (striae) on skin
- poor short-term memory
- delayed puberty
- dark or mauve-colored urine
- skin sensitivity (tags in clothes)
- sleep problems
- tinnitus (ringing in ears)
- estrogen/BCP intolerance
- PMS
- outbursts with remorse
- poor stress control
- frequent infections
- premature graying of hair
- enjoys spicy foods
- spleen-area pain
- fear of airplane travel, tornadoes, etc.
- poor wound healing
- psoriasis
- white spots on fingernails
- severe anxiety
- poor muscle development
- frequent anger
- fibromyalgia/CFS

Medical History

Primary Symptoms: _____

Onset of condition: _____

Treatments that are or were effective: _____

Treatments that failed: _____

Any family members with similar symptoms?

Please circle any of the following that apply to a relative:

temper tantrums

ADD/ADHD

cancer

panic disorder

anxiety disorder

dementia

asthma

ulcers

heart disease

stroke

bipolar disorder

kidney problems

depression

autism

psoriasis

diabetes

arthritis

schizophrenia