Dear Valued Patient,

Thank you for choosing the UNM Center for Life (CFL) for your healthcare needs. We're committed to providing you excellent care.

- Center for Life providers care about the time you wait for them. Because we care, we're ready for you when you arrive and rarely run more than a few minutes behind schedule.

Name:	DOB:	How did you hear about us?	

Would you like to receive the CFL newsletter?	Yes	No	Email Address:	

Please describe your goals/expectations for your care at the Center for Life: _____
_____
_____
_____
_____
_____

Please list any natural health products (**herbs, supplements, vitamins, special foods**) you are currently using. (Use separate sheet if necessary)	Product:	Brand:	Dose:	How Often:

General Health:

• How would you rate your general health?	Poor	Fair	Ok	Good	Great
• How would you rate your health as a child?	Poor	Fair	Ok	Good	Great
• How would you rate your energy level during the past month?	Poor	Fair	Ok	Good	Great
• How would you rate your sleep during the past month?	Poor	Fair	Ok	Good	Great
• What is your stress level during the past month?	Low	Medium		High	

• In order of importance, what causes the most stress in your life? (Job, Relationships, Health, Finances, etc.)			
• What brings you happiness?			

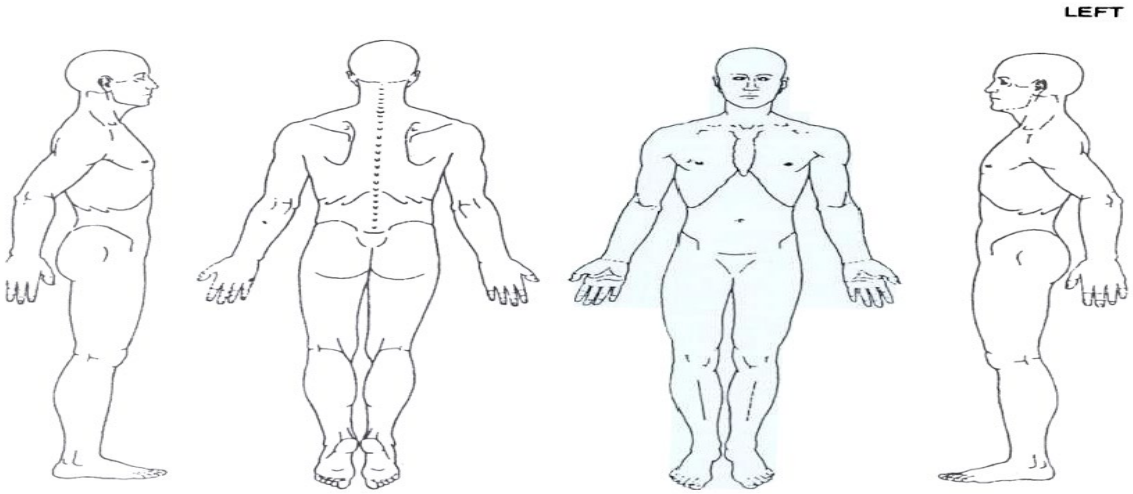
Medical History:

Diet and Nutritional History:

• How would you rate your current eating habits?	Poor	Fair	Ok	Good	Great

• In the past 24 hours, what have you eaten for:					
1. Breakfast:					
2. Lunch:					
3. Dinner:					
4. Snacks:					
• Is this what you eat on a typical day?	Yes			No	
1. If not, why not?					
• How many times do you eat out per week?	0	1-2	3-5	6-10	10+
• When you cook, what types of oils do you use?					
• Do you get cravings for certain foods? If yes, what do you crave?					
• Are there any types of foods you avoid? If yes, what do you avoid?					
• What do you drink on a typical day? (Coffee, soda, juice, water, etc.)					
1. How many 8 oz cups of water do you drink on a typical day?					
2. Which types of caffeine do you typically drink?	Coffee	Energy Drinks	Soda	Tea	
3. How much of each do you drink?					
• How many servings of fruit do you eat on a typical day? (Serving = 1 cup raw or ½ cup cooked)	0	1	2	3	4
• How many servings of vegetables do you eat on a typical day? (Serving = 1 cup raw or ½ cup cooked)	0	1	2	3	4
• Current Weight:	• Highest Ever Weight:		• Desired Weight:		

Pain History: (Please mark the areas where you are in pain.)



Area #	Current Pain Rating (0=low to 10=extreme)	Quality of the Pain (Stabbing, burning, throbbing, numb, aching, pins/needles)	When did the Pain Start?	Did the pain start around the time of an injury?		Have you had any of these tests to evaluate the pain? Xray, MRI, CT, labs		Has the pain caused you to lose time from work, change your daily activities, or lose sleep?	
1.				**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
2.				**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
3.				**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
4.				**Yes**	**No**	**Yes**	**No**	**Yes**	**No**

Do you have chronic pain? ☐ **Yes** ☐ **No** (skip section)

Chronic pain is pain lasting more than **3 months**.

Rating Scale: *0 = No Pain; 10 = Worst Pain You've Ever Had*

1. How severe is your chronic pain RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10

2. How severe is your chronic pain ON AVERAGE?											
3. What is your LOWEST level of chronic pain in the past week?											
4. What is your HIGHEST level of chronic pain in the past week?											

What treatments and/or medications do you take for pain?

Treatments:	1.	2.	3.
Medications:	1.	2.	3.
Over-the-Counter Medications:	1.	2.	3.

How much RELIEF have pain treatments or medications provided in the last week?

Rating Scale: *0 = No Relief* *10 = Complete Relief*

1. Treatment #1:	0	1	2	3	4	5	6	7	8	9	10
2. Treatment #2:	0	1	2	3	4	5	6	7	8	9	10
3. Treatment #3:	0	1	2	3	4	5	6	7	8	9	10
4. Medication #1:	0	1	2	3	4	5	6	7	8	9	10
5. Medication #2:	0	1	2	3	4	5	6	7	8	9	10
6. Medication #3:	0	1	2	3	4	5	6	7	8	9	10
7. Over-the Counter Medication #1:	0	1	2	3	4	5	6	7	8	9	10
8. Over-the Counter Medication #2:	0	1	2	3	4	5	6	7	8	9	10
9. Over-the Counter Medication #3:	0	1	2	3	4	5	6	7	8	9	10

During the past Week how has pain INTERFERRED with your Quality of Life?

Rating Scale: *0 = Does Not Interfere* *10 Completely Interferes*

1. General Activities of Living	0	1	2	3	4	5	6	7	8	9	10
2. Mood	0	1	2	3	4	5	6	7	8	9	10
3. Walking Ability	0	1	2	3	4	5	6	7	8	9	10
4. Normal Work (outside home & house work)	0	1	2	3	4	5	6	7	8	9	10
5. Relationships with Other People	0	1	2	3	4	5	6	7	8	9	10
6. Sleep	0	1	2	3	4	5	6	7	8	9	10
7. Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

Female Health History:

- Age of first menses: _____ Date/Duration of last menstrual period: _____ Age of Menopause: _____
- Pregnancies: _____ Abortions: _____ Miscarriages: ____ Live Births: _____ Premature Births: _____
- Please share with us any other female health history that may be pertinent._____

Review of Systems:

General: (Please circle any symptoms you have experienced **IN THE LAST SIX MONTHS**)

1. Recurrent infections
2. Night Sweats
3. Sweating easily
4. Weight gain / loss
5. Sudden Energy drops
6. Fever/Chills
7. Fatigue
8. Poor balance
9. Bleed or bruise easily
10. Strong thirst (hot/cold)
11. Thirst / lack of thirst
12. Other _____

Skin: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Rashes
2. Itching
3. Oozing
4. Pimples/Acne
5. Dry skin/scalp
6. Change in hair
7. Change in skin
8. Other: _____

Head/Eyes/Ears/Nose/Throat: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Headaches
2. Dizziness
3. Earache
4. Poor Hearing
5. Ringing in Ears
6. Blurry Vision
7. Night Blindness
8. Spots in front of Eyes
9. Eye Pain
10. Excessive Tearing
11. Glasses
12. Dry Eyes/Mouth
13. Facial Pain
14. Nose Bleeds
15. Nasal Discharge
16. Blocked Nose
17. Snoring
18. Grinding Teeth
19. Teeth Problems
20. Hoarseness
21. Recurrent Sore Throat
22. Swollen Glands
23. Sore on Lips/Mouth
24. Other: _____

Cardiovascular: (Please circle any symptoms you have experienced **in the last 6 months**).

1. Pacemaker
2. High Blood Pressure
3. Low Blood Pressure
4. Heart Palpitations
5. Chest Discomfort/Pain
6. Swelling of Legs
7. Blood Clots
8. Varicose Veins
9. Fainting
10. Cold Hands or Feet
11. Other: _____

Respiratory: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Difficulty Breathing
2. Pain with Breathing
3. Shallow Breathing
4. Shortness of Breath
5. Production of Phlegm
6. Recurrent Cough
7. Coughing Blood
8. Bronchitis
9. Pneumonia
10. Asthma/Wheezing
11. Use C-Pap
12. Other: _____

Digestion: (Please circle any symptoms you have experienced **in the last 6 months**).

1. Change in Appetite
2. Abdominal Pain/Cramps
3. Nausea / Vomiting
4. Reflux
5. Heartburn. Belching
6. Belching
7. Pain with Passing Stools
8. Constipation
9. Loose Stools/Diarrhea
10. Hemorrhoids
11. Rectal Pain
12. Gas
13. Other _____

Genito-Urinary: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Pain upon Urination
2. Frequent Urination
3. Blood in Urine
4. Night Incontinence
5. Impotency
6. Kidney Stones
7. Prostate Problems
8. Urgency with Urination
9. Decrease in Urinary Flow
10. Inability to Empty Bladder
11. Increase/Decrease in Sex Drive
12. Wake to Urinate
13. Unable to Hold Urine
14. Numbness in Anal or Genital Area
15. Other: _____

Gynecological: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. PMS
2. Irregular Periods
3. Painful Periods
4. Light Periods
5. Heavy Periods
6. Clots
7. Infertility
8. Unusual Vaginal Discharge
9. Vaginal Sores
10. Bleeding after Sex
11. Breast Lumps
12. Nipple Discharge
13. Other: _____

Neurological: (Please circle any symptoms you have experienced **in the last 6 months**).

1. Seizures
2. Paralysis
3. Dizziness
4. Poor Memory
5. Difficulty Concentrating
6. Weakness/Numbness
7. Lack of Coordination
8. Tremors
9. Other _____

Emotional: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Vacant
2. Moody
3. Bad Temper
4. Lose Control of Emotions
6. Depression
7. Fear
8. Anxiety or Panic
12. Eating Disorder
13. Other: _____

Is there anything else you would like to share with us about yourself, your life or your health?

_____

_____