The Gleason Center
Your Personal Path to Health

Mr. Mrs. Miss Ms. (please circle one) Last Name: _____ First Name: _____
Birthdate: _____ Today's Date: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____
Email: _____ Person Responsible for Account: _____
Medical Insurance Carrier: _____
Physician's Name: _____ Dentist's Name: _____
Occupation: _____Employer: _____
Who may we thank for referring you? _____
What is the **primary problem** you'd like Dr. Gleason to address? _____
_____
_____
When was the onset? _____How often do you experience it? _____
How long do symptoms last? _____
What treatments have you used? _____
_____
List any **secondary problems**: _____
_____
_____

Indicate **approximate dates** of any of the following:

_____ Heart Attack
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Diabetes
_____ Varicose veins
_____ Hepatitis
_____ TB
_____ Broken Bones
_____ Orthopedic Surgery
_____ Other Surgery
_____ Auto Accident
_____ Blow to Head
_____ Blow to Jaw
_____ Whiplash Injury
_____ Serious Fall
_____ Physical Therapy
_____ Dentures
_____ Bite Adjustment
_____ Orthodontic Treatment
_____ Periodontal Treatment
_____ Teeth Sensitive
_____ Difficulty Chewing

_____ MS
_____ Hypoglycemia
_____ Ulcers
_____ Constipation
_____ Diarrhea
_____ Heartburn or reflux
_____ Poor Digestion
_____ Stomach Gas
_____ Gall Bladder Disorder
_____ Hemorrhoids
_____ Kidney Disorder
_____ Frequent Urination
_____ Urgent Urination
_____ Urinary Dribbling
_____ Cancer
_____ Mononucleosis
_____ Canker Sores
_____ Fatigue
_____ Anemia
_____ Arthritis
_____ Bursitis
_____ Tendinitis

_____ Muscle Cramps
_____ Nervousness
_____ Vertigo
_____ Epilepsy
_____ Difficulty Sleeping
_____ Depression
_____ Psychotherapy
_____ Eye Pain/Pressure
_____ Eye Sensitivity to Light
_____ Sinus Trouble
_____ Headache _____ Location
_____ Migraine Headache
_____ Cold _____ Numb Hands
_____ Cold _____ Numb Feet
_____ Nosebleeds
_____ Swollen Feet or Ankles
_____ Pain _____ Stiff Shoulders
_____ Pain _____ Stiff Neck
_____ Pain _____ Stiff Mid Back
_____ Pain _____ Stiff Low Back
_____ Pain _____ Stiff Legs
_____ Acne

Women only:

_____ Menstrual problems
_____ Cramping
_____ Post-partum Depression
_____ Uterine Ablation
_____ Miscarriage(s)

_____ Excessive Flow
_____ PMS
_____ Menopause
_____ Hot flashes
_____ Number of pregnancies

_____ Clotting or dark flow
_____ Breast tenderness
_____ Hysterectomy
_____ Mood/memory problems
_____ Number of children

Have you recently experienced any of the following?

_____ Death of a loved one
_____ Divorce or separation
_____ Illness or injury to family or friend
_____ Marriage
_____ Loss or change of job
_____ Retirement
_____ Pregnancy or birth of child
_____ Sexual problems
_____ Change in personal habits
_____ Change in living conditions
Please elaborate on above: _____
_____

Does your work/daily activity include any of the following?

_____ Exposure to fumes
_____ Exposure to chemicals
_____ Mental stress
_____ Physical stress
_____ Sitting _____ Standing for long periods
_____ Bending (Frequency: _____)
_____ Lifting (Weight: _____)
_____ Working overhead
What do you like about your job? _____
_____
Environmental allergies: _____
_____

Rest, Elimination, Diet

Do you sleep on your
_____ stomach ____ side _____ back
Hours of sleep per night: _____
Do you wake up _____ rested _____ tired
Bowel movements per day: _____
Describe BMs: _____
Times you eat out per week: _____
Types of restaurants: _____
Typical breakfast: _____
_____
Typical lunch: _____
_____
Typical dinner: _____
_____
Snacks: _____
Time of day: _____
Number of cups of coffee per day: _____
Number of glasses of milk per day: _____
Number of cans/bottles of pop per day: _____
Number of alcoholic drinks per day: _____
Number of glasses of water per day: _____
City water _____ Well water _____
Number of cigarettes per day: _____
Food allergies: _____
_____
_____

Physical Activity

What does your normal exercise program include?
Type of exercise: _____
_____ hours/day _____ days/week
Type of exercise: _____
_____ hours/day _____ days/week
Type of exercise: _____
_____ hours/day _____ days/week
Type of exercise: _____
_____ hours/day _____ days/week
Other: _____
_____

List your medications/reasons for taking each:

_____
_____
_____
_____
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List your vitamin supplements: _____
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For office use only: _____
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