McCAFFREY™
HEALTH CENTER
revolutionizing healthcare

Signs & Symptoms

217-726-0151

info@mccaffreyhealth.com • mccaffreyfamilyhealth.com

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LIKE US ON FACEBOOK-WE POST GREAT HEALTH TIPS OFTEN
WATCH US ON GOOD DAY MARKETPLACE-MONDAY AND WEDNESDAY MORNINGS AT 8:00AM
LISTEN TO US ON "HOUSE CALL WITH DR SEAN MCCAFFREY" 1450AM SATURDAY MORNINGS 8:00AM

PERSONAL HISTORY

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone_____ Cell Phone _____

Email _____

Referred By: (person, FB, radio, tv) _____

Sex _____ D.O.B. _____ Height _____ Weight _____

Occupation _____ Employer _____

Chief Complaint- primary reason you are seeking help:

_____

_____

Please complete the following. This document will help us to understand your current health condition. If you have any questions please call or email us, we will be happy to help.

DESIRED HEALTH IMPROVEMENTS

In order of priority, please list **ANY** and **ALL** health concerns, ailments, aches and pains, illnesses or injuries you are seeking to improve.

MEDICAL HISTORY

Surgeries (and age at time of surgery)

1._____ age_____ 2._____ age _____

3. _____ age _____ 4._____ age _____

Prescriptions (currently taking)

1._____ 2._____

3._____ 4._____

Supplements or Over-the-Counter Meds such as Vitamins, Tylenol (currently taking)

1._____ 2._____

3._____ 4._____

Habits (Please circle all that apply):

Alcohol Chocolate Cigarettes Coffee Laxatives Tea Sugar or Sugar Substitute

Do you consider yourself: overweight average underweight

Your activity level: sedentary light moderate heavy

Are you primarily responsible for preparing your own meals? Yes No

How many meals do you eat out per week? _____

How many glasses of water do you drink per day? _____

List foods you crave:

_____

_____

List foods you avoid:

_____

_____

Any special diet or dietary restrictions? _____

Are you following a dietary regimen (weight watchers, etc)? yes no

FAMILY HISTORY *(check all that apply)* •

	Mother	Father	Siblings
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Heart Disease	_____	_____	_____
Cancer	_____	_____	_____
Arthritis	_____	_____	_____
Kidney Disease	_____	_____	_____
Diabetes	_____	_____	_____
Stomach Disorders	_____	_____	_____
Other (please list)	_____	_____	_____

DIETARY PREFERENCES

What you usually eat & drink 5 days a week, not including weekends. Please record your dietary habits below and please be specific when indicating your food choices.

MORNING MEAL

Do you usually eat breakfast? yes no
Do you eat breakfast at home? yes no
Do you use a meal substitute (slim fast, etc)? yes no

Mid-Morning Snack: _____

LUNCH

Do you usually eat lunch? yes no
Do you eat lunch at home? yes no
Do you use a meal substitute (slim fast, etc)? yes no

Mid-Afternoon Snack: _____

EVENING MEAL

Do you usually eat evening meal? yes no
Do you eat evening meal at home? yes no
Do you use a meal substitute (slim fast, etc)? yes no

Evening Snack: _____

OTHER DIETARY ITEMS

Do you chew gum? yes no
Do you use breath mints? yes no

Additional food items not listed: _____

PLEASE complete each question; some may be repeated. Please score each as follows: 3 = if this is a **MAJOR** problem (severe or happens frequently)
1 = if this is a **MINOR** problem (not severe or happens infrequently)
Blank = if you never have this problem
If you do not understand a question, please circle it and we will discuss it. J

SECTION 1

Group A
___ 1. History of speech impediment, stuttering or stammering
___ 2. Dry, itchy eyes or dry mouth
___ 3. Poor memory
___ 4. Unable to relax, become serene, or meditate
___ 5. Frequent sore or irritated throat

Group B
___ 1.History of diabetes in yourself or family
___ 2. Functional or reactive hypoglycemia
___ 3. Uncontrollable appetite (eating when not hungry)
___ 4. Desire to lose weight
___ 5. In need of a meal replacement

Group C
___ 1.History of spinal disc problems or back surgery
___ 2. Unable to tolerate stress (i.e., unable to make decisions)
___ 3. Irritated or receding gums, loose teeth
___ 4. Cold hands and feet
___ 5. Clicking jaw or TMJ discomfort

Group D
___ 1.History of having difficulty healing after athletic injuries, surgery or trauma
___ 2. Swelling of soft tissue
___ 3. Cold hands and feet
___ 4. Hot flashes, menopausal symptoms
___ 5. Chronic low back discomfort

Group E
___ 1.History of frequent canker sores, cold blisters, or boils
___ 2. Muscle & tendon weakness, discomfort in lower back and buttocks
____ 3. Slow morning starter, writer's cramp or stiffness after sitting
___ 4. Dry skin, dandruff, hair falling out
___ 5. Discomfort in the shoulders & rib cage

Group F
___ 1.History of spontaneous abortion, inability to conceive or to induce labor; low sperm count
___ 2. Tremors, stiffness after rest
___ 3. Dry skin, skin manifestations or eruptions
___ 4. Hair loss
___ 5. Chronic shoulder problems

SECTION 2

Group A
___ 1. History of lactose intolerance or gluten intolerance
___ 2. Craving or thirst for cold liquids or foods
___ 3. Intolerance of dairy products, grains or sugars
___ 4. Sensitive to air pollutants (i.e., perfumes, smoke)
___ 5. Discomfort or soreness under the left rib cage after eating

Group B
___ 1.History of food sensitivity
___ 2. Bloating after eating dairy or grains
___ 3. Loose stools after eating dairy or grains

Group C
___ 1.History of gallbladder stones or gallbladder surgery
___ 2. Loss of appetite especially for meat
___ 3. Frequent sour taste in the mouth, intolerance of fats and spicy foods
___ 4. Frequent constipation with light colored stool
___ 5. Discomfort or soreness under right rib cage or in lower right abdomen after eating

Group D
___ 1.History of diabetes in yourself or family
___ 2. Excessive appetite
___ 3. Tongue coated with thick yellow film
___ 4. Frequent bitter taste in mouth
___ 5. Discomfort or soreness in temporal area on side of head

Group E
___ 1.History of ulcers or gastritis
___ 2. Frequent heartburn or indigestion with nausea and discomfort
___ 3. Acid reflux after eating
___ 4. Frequent use of antacids
___ 5. Stomach discomfort that is relieved by eating

Group F
___ 1.History of chronic gas, bloating and distention
___ 2. Unusual fullness after eating
___ 3. Rapid ingestion of food without chewing food completely
___ 4. Avoidance of raw foods, especially vegetables
___ 5. Discomfort or soreness in the upper abdominal midline

Group G
___ 1.History of pernicious anemia
___ 2. Loss of taste for meat
___ 3. Strong desire to eat when not hungry
___ 4. Indigestion, particularly 2-3 hours after eating
___ 5. Lower bowel gas

Group H
___ 1.History of chronic indigestion
___ 2. Unusual fullness after eating
___ 3. Lower bowel gas, unaware of what foods cause the problem
___ 4. Undigested food, capsules or tablets found in the stool
___ 5. Frequent abdominal cramping or discomfort after eating

SECTION 3

Group A
___ 1. History of chronic frequent yeast infections
___ 2. Foul odor to stool, urine and/or breath
___ 3. Unusually large appetite (i.e., cannot control the urge to eat)
___ 4. Frequent or prolonged use of antibiotics
___ 5. Discomfort or soreness around naval

Group B
___ 1. History of constipation with infrequent bowel movements
___ 2. Frequent use of laxatives
___ 3. Hard, uncomfortable stools
___ 4. Less than 1 bowel movement a day
___ 5. Lower abdominal discomfort

Group C
___ 1.History of colitis or other disease of the large intestine
___ 2. Loose stools with mucous or blood in the stool
___ 3. Frequent bowel movements
___ 4. Discomfort with bowel movements
___ 5. Left lower bowel discomfort

Group D
___ 1.Always tired (i.e., unable to meet daily requirements)
___ 2. Loss of appetite or feel better when you don't eat
___ 3. Restless sleep, grinding of teeth
___ 4. Thin, difficult to gain weight
___ 5. Itching around rectum and groin

SECTION 4

Group A
___ 1. History of muscular weakness and/or atrophy
___ 2. Inability to tolerate potassium-rich foods (i.e., olives, vegetable juices, bananas)
___ 3. Frequent writer's cramp, stiffness especially after rest
___ 4. Muscle soreness and discomfort resulting from exercise
___ 5. Loss of joint range of motion, discomfort when stretching

Group B
___ 1. History of food sensitivity and non-specific digestive symptoms
___ 2. Frequent raised skin eruptions or hives in response to foods or chemicals
___ 3. Strong reactions to mosquito or insect bites
___ 4. Frequent histamine reactions (i.e., sneezing attacks)
___ 5. Discomfort associated with skin irritations

Group C
___ 1.History of deep bone or joint discomfort
___ 2. Frequent use or need for tranquilizers
___ 3. Frequent infections, need for antibiotics
___ 4. Symptoms of swelling of feet and ankles
___ 5. Any type of acute traumatic incidents/accidents

Group D
___ 1.History of osteoarthritis or gout
___ 2. Musculoskeletal discomfort, difficulty walking, etc.
___ 3. Bone and joint discomfort in the spine, hips, knees, feet or hands
___ 4. Irritation from overuse or excessive exercise
___ 5. Discomfort or soreness in the knees

Group E
___ 1.History of tuberculosis or COPD
___ 2. Skin problems
___ 3. Being treated for psoriasis
___ 4. Frequent ear infections
___ 5. Discomfort or soreness in the temporal area

Group F
___ 1.History of lymphatic congestion
___ 2. Enlarged lymph nodes
___ 3. Localized swelling
___ 4. Congestion, soft tissue
___ 5. Discomfort or soreness in the shoulders and neck

Group G
___ 1.History of poor immune response or poor ability to heal
___ 2. Lack of appetite
___ 3. Decreased sense of taste
___ 4. Problems with foot odor
___ 5. Discomfort or soreness in the hip joint(s)

SECTION 5

Group A
___ 1. History of reactive hypoglycemia
___ 2. Suffer from airborne allergies
___ 3. Dark circles under the eyes
___ 4. Nausea or vomiting-type indigestion, morning sickness
___ 5. Muscular lower back discomfort

Group B
___ 1. History of frequent bladder infections
___ 2. Frequent urination, urgency or loss of control
___ 3. Pass small amounts of urine at each voiding
___ 4. Dry skin, flaking, dandruff
___ 5. Discomfort or soreness in the lower abdomen or genital area

Group C
___ 1.History of anemia or other blood disorder
___ 2. Fatigued, tired most of the time
___ 3. Pale skin, lips and nails
___ 4. Low resistance (i.e., frequent colds and infections)
___ 5. Discomfort or soreness in the left flank area of the abdomen

Group D
___ 1. History of skin disorders, such as acne
___ 2. Frequent skin rashes or eruptions
___ 3. Have many warts or moles
___ 4. Excessive perspiration or lack of perspiration
___ 5. Muscular discomfort or soreness in the lower back

Group E
___ 1.History of hepatitis, jaundice, other liver disorder
___ 2. History of high blood pressure or medication
___ 3. Water retention, swelling of hands and feet
___ 4. Suffer from varicose veins, hemorrhoids
___ 5. Discomfort or soreness in the right flank area of the abdomen

SECTION 6

Group A
___ 1. Type A personality (driven and aggressive)
___ 2. Tend to have problems with indigestion and constipation
___ 3. Stiff joints, especially after rest
___ 4. Sensitive to sudden sounds (startle easily)
___ 5. Headaches in back of head and neck

Group B
___ 1. History of gallbladder stones or sugar
___ 2. Being treated for high blood pressure
___ 3. Frequent problems with dizziness or vertigo
___ 4. Frequent episodes of fearfulness and sleeplessness
___ 5. Frequent migraine-type headaches

Group C
___ 1.History of cataracts, glaucoma, poor vision
___ 2. Frequent head colds, runny nose, watery eyes
___ 3. Bruise easily, slow healing of cuts, sore or bleeding gums
___ 4. Frequent redness in the eyelids, “sand in your eyes”
___ 5. Frequent headaches associated with eye strain, discomfort when moving eyes

Group D
___ 1.History of chronic sinus problems
___ 2. Loss of sense of smell or an obstruction to nasal breathing
___ 3. Bothered by thick mucus discharge from the nose
___ 4. Frequent nosebleeds
___ 5. Facial discomfort or paralysis

Group E
___ 1.History of or taking medication for heart disease
___ 2. Irregular heartbeat, skipped beats
___ 3. Dryness of skin or hair, itching due to dryness
___ 4. Suffer from varicose veins, hemorrhoids
___ 5. Shoulder or chest discomfort on exertion

Group F
___ 1.History of asthma, emphysema, bronchitis, pneumonia
___ 2. Difficulty breathing, shortness of breath
___ 3. Frequent cough (dry or productive)
___ 4. Wheezing or having difficulty breathing when lying on back
___ 5. Difficult shoulder movement

Group G
___ 1.History of bone disorders, spurs, osteoporosis
___ 2. Muscle soreness and weakness
___ 3. Loose teeth or poor fitting dentures
___ 4. Restlessness, hyperirritability, or restless legs at night
___ 5. Low back discomfort, weak joints or ligaments, fallen arches

Group H
___ 1.History of injury to the tailbone
___ 2. Restlessness or difficulty sleeping
___ 3. Inability to concentrate, frequent daydreaming or nightmares
___ 4. Unresolved health problems
___ 5. Discomfort in the area of the tailbone (i.e., hurts to sit down)

SECTION 7

Group A
___ 1. History of taking medication for thyroid gland disorders
___ 2. Fast heartbeat (i.e., can feel heart racing)
___ 3. Swollen or uncomfortable breasts
___ 4. Moist warm skin (i.e. sweat easily)
___ 5. Neck, shoulder, arm, hand discomfort

Group B
___ 1. History of low blood pressure problems
___ 2. Awake after a few hours of rest and cannot go back to sleep
___ 3. Suffer from frequent periods of sadness or the inability to think clearly
___ 4. Become light-headed when meals are missed
___ 5. Suffer from frequent nightmares or panic attacks

Group C
___ 1.History of prostate disorders or medication
___ 2. Frequent night urination
___ 3. Dribbling
___ 4. Loss of sexual urge
___ 5. Discomfort radiating into the groin or testes

Group D

___ 1.History of hysterectomy or estrogen replacement therapy
___ 2. Vaginal discharge
___ 3. Excessive menstrual flow
___ 4. Lack of menstruation, scanty flow, irregular periods
___ 5. Symptoms of PMS

Group E

___ 1.Generally tired and lacking ambition or purpose
___ 2. Frequent lack of motivation, inability to get started
___ 3. Fatigued, easily tired
___ 4. Failure to meet ordinary requirements of daily activities
___ 5. Discomfort or soreness in calf muscles when climbing stairs

Thank you for filling this document out accurately. Your replies will help us to identify your health issues and develop a customized treatment plan to restore normal body function.