HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name: Date:

Address:

City: State: Zip Code:

Home Phone: Work Phone:

Mobile Phone: Email:

Date of Birth: Age:

Occupation: Marital Status:

Referred by:

Physician: Phone:

Physician's Address:

In Emergency Notify: Phone:

Main Complaint (symptoms, Western diagnosis, duration of condition, etc.):

Significant Trauma (auto accident, falls, emotional upset, etc.):

Birth History (prolonged labor, forceps delivery, complications, etc.):

Surgeries (please include date of procedure):

Allergies (drugs, food, chemical, environmental):

Medications (names & dosages) Please attach additional page if necessary:

Vitamins/Supplements/Herbs:

Exercise: Days per week: Length of workout: Type of Activity:

Personal History

Please check any conditions or symptoms you have now.

- ☐ High/Low Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Stroke
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Food Allergies/ Intolerance
- ☐ Ulcer
- ☐ Gastritis
- ☐ IBS/Diverticulitis
- ☐ Seizures
- ☐ HIV
- ☐ Liver/Gall Bladder Disease
- ☐ Hepatitis
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Chronic Pain Condition
- ☐ Arthritis
- ☐ Asthma
- ☐ Emphysema
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Thyroid Imbalance
- ☐ Raynaud's Disease
- ☐ Autoimmune Disorder

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Heart Disease _____
- ☐ Other _______________________
- ☐ Seizures _____
- ☐ Cancer _____
- ☐ Asthma/COPD _____
- ☐ Bleeding or Clotting Disorders_____
- ☐ Depression/suicide _____
- ☐ Genetic Disorders _____
- ☐ Allergies _____
- ☐ Alcholism _______
- ☐ Stroke _____

Please check if you have had any of these items listed below in the last 3 months.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ NIght Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems
- ☐ Sudden energy drop

Skin and Hair

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives/Allergic Dermatitis
- ☐ Itching
- ☐ Eczema/Psoriasis
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Skin discoloration
- ☐ Acne
- ☐ Change in skin/hair texture

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Difficulty swallowing
- ☐ Migraines
- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night Blindness
- ☐ Color Blindness
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurrent sore throats/colds
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Sores on lips/tongue
- ☐ Dental problems

Cardiovascular

- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Palpitations at rest
- ☐ Fainting
- ☐ Cold hands/feet
- ☐ Swelling of hands/ feet
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Shortness of breath
- ☐ Varicose/spider veins
- ☐ Pressure in chest
- ☐ High blood pressure
- ☐ Low blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficult inhale or exhale
- ☐ Pain with deep inhalation
- ☐ Tight sensation

Do you smoke cigarettes?___________ If so, how many per day?___________ Other Tobacco use? _______________

Do you use recreational drugs?_______ If so, what type & how often?____

Production of phlegm? _____________ What color?______________________

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bloating/Edema
- ☐ Chronic laxative use
- ☐ Loose stools (>2 per day)
- ☐ Abdominal pain/cramps
- ☐ Changes in appetite
- ☐ Acid reflux

Diet: Meals per day_________ Snacks per day________ Caffeinated drinks per day_________ Alcohol per week________

Water intake (cups per day)___________ Hot, cold, or room-temperature?_________________________________

Urogenital

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Scanty flow
- ☐ Copious flow
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Urinary tract infection
- ☐ Burning urination
- ☐ Premature ejaculation
- ☐ Decreased libido
- ☐ Prostatitis
- ☐ Dribbling after urination

Do you wake to urinate?_______ What time?______ How often?______

What color is your urine?_______________________

Gynecological/Reproductive

- ☐ Breast lumps
- ☐ Fibrocystic breast tissue
- ☐ Difficult intercourse
- ☐ Vaginal dryness
- ☐ Ovarian cysts
- ☐ Fibroid tumors
- ☐ Endometriosis
- ☐ Vaginal Sores
- ☐ Vaginal Discharge
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ PMS/Painful menstruation
- ☐ Age of first menses ______
- ☐ Date of last menses ______
- ☐ Date of last PAP ______
- ☐ # of pregnancies ______
- ☐ # of births ______
- ☐ # of premature births ______
- ☐ # of miscarriages ______
- ☐ # of abortions ______

Do you practice birth control?_________

What type?____ How long?____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Carpal Tunnel
- ☐ Knee pain
- ☐ Sprains/Strains
- ☐ Sciatica
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Tendonitis
- ☐ Bursitis Rotator Cuff
- ☐ Back pain
  - Low___
  - Middle___
  - Upper___

Neurological/Psychological

- ☐ Seizures
- ☐ Loss of balance
- ☐ Vertigo/Dizziness
- ☐ Areas of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety/Panic attacks
- ☐ Bad temper/irritable
- ☐ Easily susceptible to stress
- ☐ Seasonal affective disorder

Have you ever been treated for emotional problems? ____

Have you ever considered or attempted suicide? ____

Have you ever been treated for substance abuse? ____

Comments

Please tell us of any other issues you would like to discuss.