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 your answers are absolutely confidential. If you have any questions, please ask.

PERSONAL INFORMATION

Name: ____ Date: ___________________

Address:____

City: ____ State: ________ Zip: ____________________

Home Phone: _______________________________ Work Phone: _________________________________

Mobile Phone: ___________________________ E-Mail: ____

Date of Birth: _______________________ Age: ________________ Marital Status: ________________

Referred by: _______________________________ Occupation: ___________________________________

Physician: ____ Phone: __________________________

Address: ________________________________ City: _________________ State: ______ Zip: ________

In Emergency Notify: ___________________________________ Phone: ____________________________

MAIN COMPLAINTS (symptoms, diagnosis, duration, etc.)

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Significant Trauma (physical or emotional)

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

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

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

Vitamins/Supplements/Herbs

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks Caffeinated Drinks Alcohol per week

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Please check any conditions or symptoms you have now.

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

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 ___ ☐Seizures ___ ☐Heart Disease ___ ☐Stroke ___
☐High Blood Pressure ___ ☐Allergies ___ ☐Cancer ___ ☐Asthma ___
☐Other____

Please **check** if you have had any of these items listed below in the last **year**
Put a **star** on the box if you had this in the past but do not any longer.

General

☐Poor Appetite ☐Poor Sleeping ☐Fatigue ☐Fevers
☐Chills ☐Night Sweats ☐Sweats Easily ☐Tremors
☐Cravings ☐Localized Weakness ☐Poor Balance ☐Change in appetite
☐Bleed/Bruise easily ☐Weight loss/gain ☐Peculiar tastes/smells ☐Dental/gum problems
☐Muscle weakness/fatigue ☐Sudden energy drop ☐Strong thirst (hot or cold drinks)

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 ☐Face flushing
☐Dermatitis ☐Warts ☐Fungal Infection ☐Weak or ridged nails

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 ☐Jaw clicks/locks ☐Headaches

Cardiovascular

☐Chest pain or pressure ☐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 ☐Spontaneous sweating ☐Dizziness

Respiratory

☐Cough/Wheezing ☐Coughing blood ☐Asthma ☐Bronchitis
☐Pneumonia ☐Pain with deep inhalation ☐Tight sensation in chest ☐Difficult inhale/exhale
☐Difficulty breathing when lying down ☐Production of phlegm... what color?
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Gastrointestinal

- ☐Nausea
- ☐Gas
- ☐Indigestion
- ☐Bloating/Edema
- ☐Changes in appetite
- ☐Excessive appetite
- ☐Vomiting
- ☐Belching
- ☐Bad breath
- ☐Chronic laxative use
- ☐Acid reflux/GERD
- ☐Significant thirst
- ☐Diarrhea
- ☐Black stools
- ☐Rectal pain
- ☐Loose stools (>2 per day)
- ☐Hernia
- ☐IBS/Crohn's Disease
- ☐Constipation
- ☐Blood in stool
- ☐Hemorrhoids
- ☐Abdominal pain/cramps
- ☐Poor appetite

Genito-Urinary

- ☐Pain on urination
- ☐Unable to hold urine
- ☐Impotence
- ☐Premature ejaculation
- ☐Nocturnal emission
- ☐Night urination… What time?______ How often?______
- ☐Frequent urination
- ☐Kidney stones
- ☐Sores on genitals
- ☐Decreased libido
- ☐Pain in testicles
- ☐Blood in urine
- ☐Scanty flow
- ☐Urinary tract infection
- ☐Prostatitis
- ☐Herpes
- ☐Urgent urination
- ☐Copious flow
- ☐Burning urination
- ☐Dribbling after urination
- ☐Infections
- ☐Excessive libido

Gynecological/Reproductive

- ☐Difficult/Painful intercourse
- ☐Vaginal dryness
- ☐Vaginal sores
- ☐Vaginal discharge
- ☐Infertility
- ☐Irregular menstruation
- ☐Ovarian cysts
- ☐Endometriosis
- ☐Uterine Fibroids
- ☐Fibrocystic breast tissue
- ☐Polycystic Ovarian Disease
- ☐PMS
- ☐Painful menstruation
- ☐Age of first menses_________
- ☐Date of last menses_________
- ☐Date of last PAP/Pelvic_________
- ☐Number of pregnancies____
- ☐Number of ectopic pregancies_______
- ☐Number of live births_______
- ☐Number of miscarriages_______
- ☐Number of abortions ______

Are you pregnant?________
Do you practice birth control?________
What type?______________ How long?_____________________________

Musculoskeletal

- ☐Neck pain
- ☐Knee pain
- ☐Hip pain
- ☐Back pain Low___ Middle___ Upper___
- ☐Soreness/weakness in lower body (back, knee, hip, ankle, foot)
- ☐Shoulder pain
- ☐Sprains/Strains
- ☐Muscle pain
- ☐Hand/wrist pain
- ☐Sciatica
- ☐Muscle weakness
- ☐Bursitis
- ☐Carpal Tunnel
- ☐Foot/ankle pain
- ☐Tendonitis
- ☐Rotator Cuff

Neuropsychological

- ☐Seizures
- ☐Lack of coordination
- ☐Anxiety/Panic attacks
- ☐Nervousness
- ☐Loss of balance
- ☐Poor memory
- ☐Bad temper/irritable
- ☐ADD/ADHD
- ☐Vertigo/Dizziness
- ☐Concussion
- ☐Easily susceptible to stress
- ☐Manic Depression
- ☐Areas of numbness
- ☐Depression
- ☐Seasonal Affective Disorder

Have you ever been treated for emotional problems? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No
Have you ever been treated for substance abuse? ☐Yes ☐No

Comments Please inform me of any other problems you would like to discuss.

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