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.

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 Complaint (symptoms, diagnosis, duration, etc.)

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

Personal History

Please check any conditions or symptoms you have now.

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

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
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

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

Head, Eyes, Ears, Nose and Throat

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

Cardiovascular

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

Respiratory

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

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/GERD	☐Hernia	☐Poor appetite
☐Excessive appetite	☐Significant thirst	☐IBS/Crohn's Disease	

Genito-Urinary

☐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
☐Nocturnal emission	☐Pain in testicles	☐Herpes	☐Infections

☐Night urination… What time?_____ How often?_____

Gynecological/Reproductive

☐Difficult/Painful intercourse	☐Ovarian cysts	☐Age of first menses_____
☐Vaginal dryness	☐Endometriosis	☐Date of last menses_____
☐Vaginal sores	☐Uterine Fibroids	☐Date of last PAP/Pelvic_____
☐Vaginal discharge	☐Fibrocystic breast tissue	☐Number of pregnancies____
☐Infertility	☐Polycystic Ovarian Disease	☐Number of ectopic pregancies_____
☐Irregular menstruation	☐PMS	☐Number of live births_____
	☐Painful menstruation	☐Number of miscarriages_____
		☐Number 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
☐Back pain Low___ Middle___ Upper___		☐Bursitis	☐Rotator Cuff

Neuropsychological

☐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
☐Nervousness	☐ADD/ADHD	☐Manic Depression	

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.

_____

_____

_____