

Health History Questionnaire

Date: ___ / ___ / ___

Patient's Name (Last, First, M.I.)		DOB	Sex (M/F)	What is your age today?	Your email address?
Patient's Address (No. Street)		City		State	Zip Code
Phone Number () ()	Cell or Work Number () ()	Is it OK to leave messages on this line?		Do you have out of network insurance benefits?	

Emergency Contact Information: _____

Were you referred by anyone? _____

What is your main concern today? Have you been given a Western diagnosis? _____

When did this issue begin? Is the cause still present? (Please be specific) _____

What treatments have you tried? What other kinds of practitioners have you seen? What were the results?

How would your life be different if this concern were no longer present? What would your life look like? What would you do differently? How would your relationships change?

Please take a moment and on a separate sheet, write a list of the things in your life you are grateful for. Please bring this list with you. You will not be required to share it, but we will use the list during treatment.

What is the intensity of your concern right now? Please rank from 1-5 (1=barely notice it and 5=I'm the most uncomfortable I've been in a long while.)

1 2 3 4 5

How has your issue changed within the last week?

Have you noticed what makes your concern better?

Have you noticed what makes your concern worse?

Have you noticed any other correlations (i.e. changes with emotions or stress)?

Are there any other concerns you would like to focus on with treatment?

Patient Name: _____

Date: _____

Patient's Past Medical History Please indicate by date(s) if you have been diagnosed with any of the following:

- | | | | |
|-----------------|---------------------------|-----------------------|------------------------|
| Cancer _____ | High Blood Pressure _____ | Rheumatic Fever _____ | Venereal Disease _____ |
| Diabetes _____ | Heart Disease _____ | Seizures _____ | Asthma _____ |
| Hepatitis _____ | Stroke _____ | Thyroid Disease _____ | Pacemaker _____ |
| Other: _____ | | | |

Surgeries (type and date): _____

Significant Trauma (auto accidents, falls, etc.): _____

Significant Dental Work (type and date): _____

Allergies (drugs, chemicals, foods, animals): _____

Family Medical History (Please check those that apply to your family medical history.)

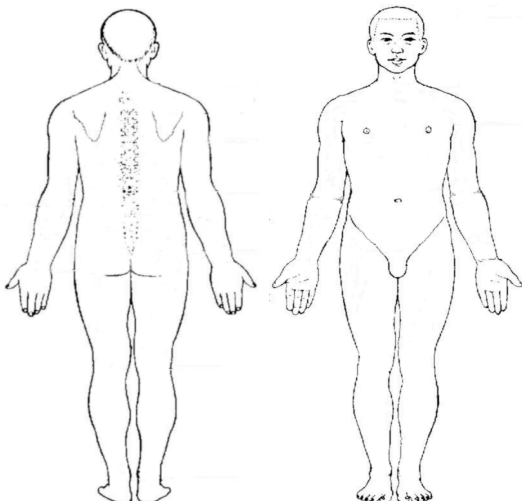
- | | | | |
|--|-------------------------------------|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | _____ | _____ |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Asthma | _____ | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | _____ | _____ |

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you exercise regularly? Y or N Please describe: _____

Comments (is there anything I have forgotten to ask which is important for me to know?): _____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of the symptoms you have had in the past 2 weeks.

Patient Name: _____

Date: _____

General

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold / hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
- Time of day: _____
- Edema
- Where: _____
- Poor sleeping
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight change
- Gain / Loss _____

Skin and Hair

- Rashes
- Itching
- Change in hair or skin
- Eczema
- Oozing skin lesion
- Hives
- Pimples
- Recent moles
- Loss of hair
- Dandruff
- Other hair or skin problems _____

**Head, Eyes, Ears
Nose, and Throat**

- Dizziness
- Migraines
- Headaches
- When: _____
- Where: _____
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision

- Color blindness
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye Dryness
- Excessive tearing
- Discharge from eyes
- Poor hearing
- Ringing in ears
- High or Low Pitch _____
- Earaches
- Discharge from ear
- Nose bleeds
- Sinus congestion
- Nasal drainage
- Grinding teeth
- Teeth problems
- Jaw clicks
- Concussions
- Recurrent sore throats
- Hoarseness
- Sores on lips/tongue
- Other head / neck problems _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest discomfort/pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Blood clots
- Fainting
- Difficulty in breathing
- Other heart/blood vessel problems: _____

Respiratory

- Cough
- Asthma/wheezing
- Difficulty in breathing when lying down
- Phlegm
- Color? _____
- Coughing blood
- Pneumonia
- Bronchitis
- Other lung problems: _____

Gastrointestinal

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion
- Diarrhea
- Constipation
- Chronic laxative use
- Blood in stools
- Black stools
- Abdominal pain/cramps
- Gas
- Rectal pain
- Hemorrhoids
- Other stomach or intestinal problems: _____

Genito-Urinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Blood in urine
- Decrease in flow
- Dribbling
- Kidney stones
- Impotency
- Change of sexual drive
- Sores on genitals
- Do you wake to urinate? Yes No
- How often? _____
- What color is your urine? _____
- Other genital or urinary system problems? _____

Pregnancy and Gynecology

- # of pregnancies: _____
- # of births: _____
- # premature births: _____
- # of miscarriages: _____
- # of abortions: _____
- Age at first menses: _____
- Length of full cycle: _____
- Length of menses: _____
- Menopause? (If yes, answer questions for history information.)
- Last menses start date: _____

- Heavy periods
- Light periods
- Painful periods
- Irregular periods
- Changes in body/psyche prior to menstruation
- Clots
- Vaginal discharge:
- Menopause: Age: _____ Year: _____
- Postcoital bleeding
- Vaginal sores
- Breast lumps
- Nipple discharge
- Do you practice birth control? Yes No
- What type and for how long? _____

Musculoskeletal

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pain
- Hip pain
- Knee pain
- Foot/ankle pain
- Muscle pain
- Muscle weakness
- Other pain? _____

Neuropsychological

- Seizures
- Areas of numbness
- Weakness
- Sleep disorder
- Concussion
- Violence potential
- Vertigo
- Lack of coordination
- Bad temper
- Depression
- Easily stressed
- Loss of balance
- Poor memory
- Anxiety
- Substance abuse
- Have you ever been treated for emotional problems? Yes No

Patient Name: _____

Date: _____

Last Physical Date: _____ Doctor: _____ Results: _____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diet :

Do you have any known food allergies?.....
.....

Please give a general description of the food you eat during a "typical" day.

Morning:

Afternoon:

Evening:

Before bed:

Between meals:

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the approx start/stop dates:

What medicines have you taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

Do you have any other allergies not yet listed? What reactions do you have to chemicals, etc?
