Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention, which is not included on this form, please note it in the Comments section or speak to us about it. Thank you.

Name:____Home Phone:_______________Cell Phone:_________________

Address:______________________________________City:___________________State:__________Zip:____________

Email address:____ Would you like to be on the mailing list?:_________

Date of Birth: ___________________Height:_______________Weight:________________Marital Status:___

Emergency Contact Name:______________________________Emergency Contact Phone:______________________

Referred By:__________________________________Family Physician:_____________________________________

What is the main problem (s) you would like help with today? (List in order of importance)

1.____

2.____

3.____

How long ago did this problem begin? (please be specific)

1.____________________________________2.____________________________3.____________________________

What was the cause of this problem: ____

____

What makes it better: (hot, cold, massage, etc.)____

____

What makes it worse: (activity, weather, AM, PM) ____

____

What kind of treatment have you tried?____

____

What treatment has been helpful?____

Is your current condition getting: ________better ________worse ________comes & goes ________same

Past Medical History*: Please include dates.*

Cancer________________________High Blood Pressure____________________Thyroid Disease________________

Heart Disease__________________Rheumatic Fever ______________________Venereal Disease________________

Diabetes______________________Seizures_______________________________Hepatitis______________________

Other:____

Surgeries (*Types and Dates*):____________________

____

Significant Trauma Incidents (auto accidents, falls, hitting head, broken bones, etc.) *Please include dates*:__________

____

Allergies: (*To what/ how long?)*____________________

____

Asthma: (*How long?)*____________________

Do you have a regular exercise program? If so, please describe: ____________________

____

Please describe your average daily diet: Morning:____________________

Afternoon:____________________Evening:____________________

How many cigarettes do you smoke a day?______________ How much coffee/tea or cola do you drink per day?______________

How much alcohol do you drink per week? ______________ How much nicotine do you chew per week? ______________

Please describe any use of drugs for non-medical purposes: ____________________

Please check any symptoms you have had in the last three months

GENERAL

- ❑ Chills
- ❑ Fevers
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot)
- ❑ No thirst
- ❑ Fatigue
- ❑ Sudden Energy drop
- ❑ Edema
- ❑ Poor sleeping
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Weight gain
- ❑ Weight loss

SKIN AND HAIR

- ❑ Rashes
- ❑ Itching
- ❑ Ulcerations
- ❑ Eczema
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff

FACE, EARS, EYES, NOSE & THROAT

- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
- ❑ Glasses
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Dry eyes
- ❑ Blind spot(s)
- ❑ Spots in front of eyes
- ❑ Eye pain
- ❑ Cataracts
- ❑ Excessive tearing
- ❑ Discharge from eyes
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Earache
- ❑ Ear discharge
- ❑ Grinding teeth
- ❑ Jaw clicks
- ❑ Jaw tension
- ❑ Teeth problems
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Sores on lips or tongue
- ❑ Hoarseness
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Facial pain

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Chest pain/discomfort
- ❑ Cold hands or feet
- ❑ Swelling in hands or feet
- ❑ Blood clots
- ❑ Phlebitis
- ❑ Fainting
- ❑ Difficulty breathing

RESPIRATORY

- ❑ Cough
- ❑ Asthma/Wheezing
- ❑ Pain with deep breath
- ❑ Difficulty breathing when lying down
- ❑ Production of phlegm
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Bronchitis

GASTRO-INTESTINAL

- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Belching
- ❑ Ulcers
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Laxative use
- ❑ Gas
- ❑ Rectal pain
- ❑ Hemorrhoids

GENITO-URINARY

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Blood in urine
- ❑ Incomplete urination
- ❑ Dribbling
- ❑ Decrease in flow
- ❑ Kidney stones
- ❑ Impotency
- ❑ Sores on genitals
- ❑ Pain with intercourse
- ❑ Change in sexual drive
- ❑ Waking at night to urinate
- ❑ How often___________
- ❑ Peculiar color
- ❑ Particular odor

PREGNANCY & GYNECOLOGY

Number of pregnancies_________
Number of births______________
Number or premature births______________
Number of miscarriages_________
Number of abortions___________
Number of ectopic pregnancies___________
Age at first menses______________
How many days between menses____________
Duration of menses____________
Date of last menses__________

- ❑ Heavy periods
- ❑ Light periods
- ❑ Painful periods
- ❑ PMS
- ❑ Clots
- ❑ Menopause
- ❑ Breast lumps
- ❑ Nipple discharge

Last PAP___________

- ❑ Birth control

Type_______________
How long____________

MUSCULO-SKELETAL

- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Mid-back pain
- ❑ Spinal pain
- ❑ Elbow pain
- ❑ Hand/wrist pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Muscle pain
- ❑ Muscle weakness

NEURO-PSYCHOLOGICAL

- ❑ Seizures
- ❑ Numbness
- ❑ Weakness
- ❑ Sleep problems/disorder
- ❑ Bad dreams
- ❑ Concussion
- ❑ Bad temper
- ❑ Mood swings
- ❑ S.A.D.
- ❑ Violent potential
- ❑ Vertigo
- ❑ Loss of balance
- ❑ Lack of coordination
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse
- ❑ Ever treated for emotional problems
- ❑ Ever attempted or considered suicide

Please note the degree of severity of your problem today:

|____________________________________|____________________________________|

Low/No Problem *High/Worst Imaginable*

Please note the greatest degree of severity of your problem in the past week:

|____________________________________|____________________________________|

Low/No Problem *High/Worst Imaginable*

Comments: *Please tell me any other problems you would like to discuss*____________________

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