Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to carefully fill out this questionnaire. 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 asked on this form, please note it in the Comments Section. Thank you.

Date: ___________________

Name:				
Street:				
City/State/Zip:				
Age: Height:	Weight:	Sex (M/F):	Marital Status:	
Phone - Home:	Cell:		Work:	
Date of Birth:	Soc. Sec. #:		Occupation:	
Religion/Spiritual Practice:		Family Physician:		
E-Mail Address:				
Referred by:		Children? Ages?:		
In Emergency Notify:			Relationship:	
Will you be requiring a Superbill to submit to your insurance company?				
YES: _______	**NO: ______**			
RESPONSIBLE PARTY: If someone *other* than the patient is responsible for payment, please complete:				
Name:		Relationship:		
Address:	City/State/Zip		Phone:	

Health challenge(s) you would like us to help you with:_____________________________________

____

To what extent does this challenge affect your daily activities (work, sleep, eating, etc.)________

____

How long has it been since you first noticed your symptoms? ______________________________

____

Have you ever been given a diagnosis? If so, what? ____________________________________

____

What kinds of treatment have you tried?____

____

Past medical history (please include dates):

Significant Illnesses: ☐Cancer ☐Diabetes ☐Hepatitis

☐High Blood Pressure ☐Heart Disease ☐Seizures ☐Rheumatic Fever

☐Thyroid Disease ☐Venereal Disease: if yes, which one(s):___________________________

☐Other Illnesses:

____

Surgeries:____

Significant Trauma:____

Antibiotic use history: ____

Steroid, hormone, and/or birth control history:____

____

Your birth history (prolonged labor, forceps delivery, etc.):_________________________________

Allergies:____

Number of fillings? _______ What material? (silver, porcelain, etc.)____________ # of root canals:_______

Other Relevant Dental History:____

Other Relevant Medical History:____

List any of the following exams you've had recently:

Exam:	Date:	Result:
Physical exam		
Cholesterol		
Blood Pressure		
Mammogram		
Thermography		
Biopsies		
Pap Smear		
Blood Tests		
Bone Density		
Colonoscopy		
Dental Exam		
Other		

Family Medical History:

□Diabetes □Cancer □High Blood Pressure □Heart Disease □Stroke

□Seizures □Asthma □Allergies:____

Medicines/supplements and dosages taken within the last two months:

(include vitamins, supplements, herbs, prescription medicine, over-the-counter medicine, etc.):

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

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

Occupational Stress Factors (physical, psychological, chemical):___________________________

Do you follow a regular exercise program?___ If so, please describe:__________________________

____

Have you ever been on a restricted diet?____ What kind?____________________________________

Please describe your average daily diet:

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Do you smoke?________________ How many packs per day?_______________________

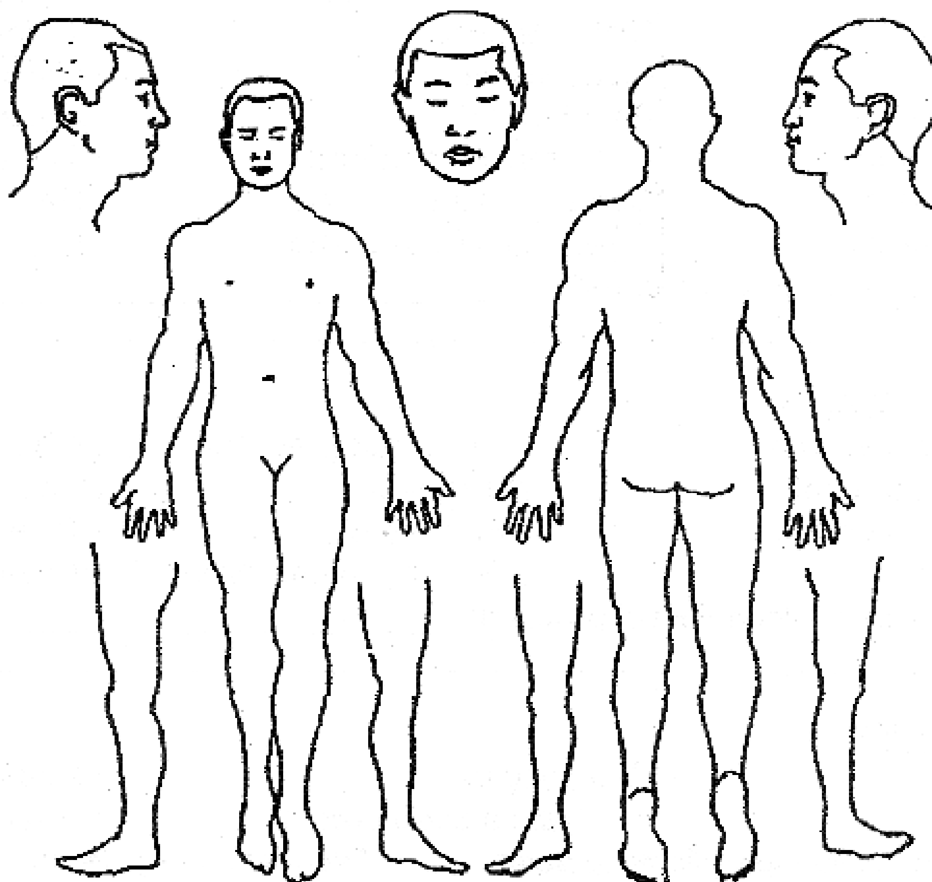
How much coffee, tea, or cola do you drink per week?_______________________________________

How much alcohol do you drink per week? ____

How much water do you drink per day?____

Indicate painful or distressed areas:

Symbol	Reaction
Pain on Pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
	normal
#	tense
Spontaneous pain	
▯	slight
▯▯	moderate
▯▯▯	severe
Pulsing	
◦	slight
◦ ◦	moderate
◦ ◦ ◦	strong
Temperature	
-	colder
	normal
+	hotter
Physical	
☼	sores
± ±	rashes
→←	spasms



Please check if you have had (in the last three months):

GENERAL

☐Poor appetite
☐Poor sleeping
☐Poor balance
☐Localized weakness
Where?
☐Strong thirst (cold or hot drinks?)
☐Night sweats
☐Sudden energy drop (time?)
☐Weight Loss
☐Fever
☐Sweat easily
☐Night sweats
☐Tremors
☐Bleed/bruise easily
☐Cravings
☐Weight gain
☐Change in appetite
☐Chills

Any other unusual or abnormal conditions you have noticed in your general sense of health?

SKIN

☐Rashes
☐Ulcerations
☐Hives

☐Itching ☐Eczema ☐Pimples
☐Dandruff ☐Loss of hair ☐Recent moles
☐Change in hair or skin texture
Any other hair or skin problems?____

HEAD, EYES, EARS, NOSE AND THROAT

☐Dizziness ☐Concussions ☐Migraines
☐Glasses ☐Spots in front of eyes ☐Eye pain
☐Poor vision ☐Night blindness ☐Color blindness
☐Cataracts ☐Blurry vision ☐Earaches
☐Ringing in ears ☐Poor hearing ☐Eyestrain
☐Sinus problems ☐Recurrent sore throats ☐Nose bleeds
☐Grinding teeth ☐Sores on lips or tongue ☐Facial pain
☐Teeth problems ☐Headaches (where and when) ☐Jaw clicks
Any other head or neck problems?____
____

CARDIOVASCULAR

☐High blood pressure ☐Low blood pressure ☐Chest pain
☐Irregular heartbeat ☐Dizziness ☐Fainting
☐Colds hands or feet ☐Swelling of hands ☐Swelling of feet
☐Blood clots ☐Difficulty in breathing ☐Phlebitis
Any other heart or blood vessel problems?____
____

RESPIRATORY

☐Cough ☐Coughing blood ☐Asthma
☐Bronchitis ☐Pain with a deep breath ☐Pneumonia
☐Difficulty in breathing while lying down ☐Production of phlegm What color?______
Any other lung problems?____

GASTROINTESTINAL

☐Nausea ☐Vomiting ☐Diarrhea
☐Constipation ☐Gas ☐Belching
☐Black Stool ☐Blood in stools ☐Indigestion
☐Bad Breath ☐Rectal pain ☐Hemorrhoids
☐Abdominal pain/cramps ☐Chronic laxative use
Any other problems with your stomach or intestines?_____________________________________

GENITO-URINARY

☐Pain on urination ☐Frequent urination ☐Blood in urination
☐Urgency to urinate ☐Unable to hold urine ☐Kidney stones
☐Decrease in flow ☐Impotency ☐Sores on genitals
Do you wake up at night to urinate?________ How often?_________________________________
Any particular color to your urine?____
Any other problems with your genital or urinary systems?__________________________________

REPRODUCTIVE & GYNECOLOGIC (women only)

______Number of pregnancies ______Number of births ______Premature births
______Number of miscarriages ______Age at first menses ______Abortion(s)
______Date of last menses ______Duration of menses
______Length of time between menses
□Unusual character (heavy or light) □Clots □Painful periods
□Irregular periods □PMS □Vaginal discharge
□Vaginal Sores □Breast lumps □Menopause (age________)
□Other gynecological issues (ie: fibroids, endometrosis):____________________________________
Do you practice birth control?______ What type?_____________ For how long?______________
Have you ***ever*** taken birth control pills? ___________ Last PAP:_________________

MUSCULOSKELETAL

□Neck pain □Muscle pains □Knee pain
□Back pain □Muscle weakness □Foot/ankle pains
□Hand/wrist pains □Shoulder pains □Hip pain
Any other joint or bone problems?____

NEUROPSYCHOLOGICAL

□Seizures □Areas of numbness □Loss of balance
□Dizziness □Lack of coordination □Poor memory
□Concussion □Depression □Anxiety
□Bad temper □Easily susceptible to stress
Have you ever been treated for emotional problems?______________________________________
Have you ever considered or attempted suicide?____
Any other neurological or psychological problems?____

Please describe your current emotional health:____
Do you enjoy your work/co-workers?____
Do you feel reasonable job security?____
Are you in a supportive family/home environment?____
Do you have opportunities to express and receive love?____________________________________
Do you trust that you will always have enough of what you need?___________________________
Do you have sufficient creative expression?____
Does your environment feel like a sanctuary, free of clutter?________________________________
Do you make time for relaxation during the course of your day?_____________________________
Do you enjoy deep, restful sleep?____
When was your last vacation?____
Are your relationships harmonious?____
Do you have close friends with whom you can confide and trust?____________________________
Are you involved in community activities (church, social or service organizations, support groups,

volunteerism)?____
Please describe your energy level:____
Please describe your childhood nutrition:____
How would you rate your current eating habits?____

Do you, or have you ever had an eating disorder?________________________________

What foods do you crave?____
Do you eat out often?____
Do you chew your food well?______________ Do you eat in a rushed manner?__________
Do you eat processed foods?____
Do you want to gain/lose weight?___________ If so, how many pounds?________________

Have you had any exposure to chemicals?______________________________________
____

COMMENTS:
Please tell us of any other issues you would like to discuss:___________________________
____
____
____
____