Patient Name:_____ DOB:_____Today's Date:_____

Health History

Thank you for taking the time to fill out this form as completely as possible. To give you the best possible care, it is essential for me to have a thorough understanding of your past and present health.

Please note that all information is confidential.

Name_____Date_____

Address_____ zip_____

Phone_____ Email _____

Date of Birth_____ Age_____ Gender_____ Height_____ Weight_____

Is it alright to leave a message about your care? Yes No

Emergency Contact_____ Phone_____

Physician_____ Phone_____

How did you hear about my services? _____

What brings you in today? _____

_____

When and how did this condition begin?_____

What types of treatments have you tried and what were the results?_____

_____

How does this condition impact your daily activities?_____

_____

Please list the main health problems you would like to address in order of importance:

1. _____
2. _____
3. _____

Please list any medications, vitamins, or supplements you are taking. (use page back if needed)

Medication & Dosage Reason For How Long

_____

_____

_____

_____

Please list all surgeries, major illnesses, hospitalizations, and major accidents and when they occurred. _____

_____

_____

Please list any allergies and your response to them (medications, foods, animals, environmental substances, etc.) _____

_____

Patient Name:_____ DOB:_____Today's Date:_____

Are you or might you be pregnant? Yes No
Do you have a history of seizures? Yes No
Do you have a history of fainting? Yes No
Do you have a pace-maker? Yes No

Please circle any childhood conditions that you have had.
Scarlet Fever Diphtheria Rheumatic Fever Measles Mumps
German Measles Chicken Pox Childhood Ashtma Other_____
Please list any significant health conditions that have occurred in your family members.

Condition	Relation to you
_____	_____
_____	_____
_____	_____

Please circle all that apply.

0=never 1=rarely 2=occasionally
3=frequently 4=always

Energy and Immunity

0 1 2 3 4 fatigue
0 1 2 3 4 catch colds easily
0 1 2 3 4 slow wound healing
0 1 2 3 4 feel worse after exercise
0 1 2 3 4 chronic infection
____ HIV/AIDS
other _____

Musculoskeletal

0 1 2 3 4 neck / shoulder pain
0 1 2 3 4 low back pain
0 1 2 3 4 mid back pain
0 1 2 3 4 upper back pain
0 1 2 3 4 arm / hand pain
0 1 2 3 4 leg / foot pain
0 1 2 3 4 muscle spasms / cramping
0 1 2 3 4 joint pain _____
other _____

Gastrointestinal

0 1 2 3 4 digestive problems
0 1 2 3 4 low appetite
0 1 2 3 4 insatiable appetite
0 1 2 3 4 fatigue after meals
0 1 2 3 4 gas or bloating after meals
0 1 2 3 4 ulcers
0 1 2 3 4 acid reflux
0 1 2 3 4 nausea or vomiting
0 1 2 3 4 stomach pain
0 1 2 3 4 heartburn
0 1 2 3 4 belching
0 1 2 3 4 constipation
0 1 2 3 4 diarrhea
0 1 2 3 4 blood in stools
0 1 2 3 4 mucous in stools
0 1 2 3 4 undigested food in stools
____ parasites _____
____ liver disease
____ gall bladder disease
____ hepatitis B / C

Patient Name:_____ DOB:_____Today's Date:_____

0=never 1=rarely 2=occasionally 3=frequently 4=always

Respiratory

0 1 2 3 4 cough
0 1 2 3 4 asthma
0 1 2 3 4 difficulty breathing
0 1 2 3 4 pneumonia
____ emphysema
____ pleurisy
____ tuberculosis
other _____

Head, Eye, Ear, Nose, & Throat

0 1 2 3 4 headaches
0 1 2 3 4 sinus congestion
0 1 2 3 4 nasal discharge
0 1 2 3 4 nose bleeds
0 1 2 3 4 dry nose/mouth/throat
0 1 2 3 4 sore throat
0 1 2 3 4 bleeding or swollen gums
0 1 2 3 4 cold sores / canker sores
0 1 2 3 4 floaters in vision
0 1 2 3 4 eye pain / strain
0 1 2 3 4 excess tearing or dryness of eyes
0 1 2 3 4 blurry vision
0 1 2 3 4 ear ringing
0 1 2 3 4 ear pain
0 1 2 3 4 hearing loss
0 1 2 3 4 jaw pain or popping
other _____

Neurologic

0 1 2 3 4 dizziness / vertigo
0 1 2 3 4 paralysis
0 1 2 3 4 numbness / tingling
0 1 2 3 4 seizures
0 1 2 3 4 balance problems
0 1 2 3 4 muscle weakness
other _____

Cardiovascular

0 1 2 3 4 palpitations
0 1 2 3 4 chest pain
0 1 2 3 4 ankle swelling
0 1 2 3 4 varicose veins
0 1 2 3 4 fainting
____ stroke
____ heart murmur
____ heart disease
____ high blood pressure

Genito-Urinary

0 1 2 3 4 painful urination
0 1 2 3 4 frequent urination
0 1 2 3 4 urinary dribbling
0 1 2 3 4 urinary incontinence
0 1 2 3 4 urinary tract infection
0 1 2 3 4 kidney stones
0 1 2 3 4 blood in urine
____ kidney disease
____ venereal disease
other _____

Endocrine

0 1 2 3 4 feeling hot or cold
0 1 2 3 4 night sweats
____ hypoglycemia
____ hyperthyroid
____ hypothyroid
____ diabetes (Type 1 / 2)
other _____

Patient Name:_____ DOB:_____Today's Date:_____

0=never 1=rarely 2=occasionally 3=frequently 4=always

Emotional

0 1 2 3 4 mood swings
0 1 2 3 4 nervousness
0 1 2 3 4 nightmares
0 1 2 3 4 feeling low in spirits
0 1 2 3 4 restlessness
0 1 2 3 4 excessive worry
0 1 2 3 4 anxiety
0 1 2 3 4 panic attacks
0 1 2 3 4 contentment
0 1 2 3 4 fulfillment
0 1 2 3 4 have a sense of purpose
other _____

Other

0 1 2 3 4 insomnia
0 1 2 3 4 anemia
0 1 2 3 4 eczema / hives/ rashes
0 1 2 3 4 cold hands / feet
0 1 2 3 4 bruises easily
0 1 2 3 4 extreme thirst
0 1 2 3 4 brittle nails
0 1 2 3 4 hair loss or thinning
0 1 2 3 4 dry skin
0 1 2 3 4 itching
____ osteoporosis
____ cancer
other _____
_____

Women's Health

0 1 2 3 4 irregular cycles
0 1 2 3 4 heavy periods
0 1 2 3 4 light periods
0 1 2 3 4 bleeding between periods
0 1 2 3 4 clotting
0 1 2 3 4 vaginal discharge
0 1 2 3 4 PMS symptoms_____
_____
0 1 2 3 4 menopausal symptoms_____
_____
0 1 2 3 4 nipple discharge
0 1 2 3 4 breast lumps
0 1 2 3 4 breast tenderness
age of first period _____
age of menopause _____
# of bleeding days _____
length of cycle or month: _____ days
# of pregnancies _____
# of miscarriages _____
# of live births _____
# of abortions _____
birth control _____
___ sexual difficulties _____

Men's Health

0 1 2 3 4 prostate problems
any related diagnosis:_____
0 1 2 3 4 testicular pain / swelling
0 1 2 3 4 penile discharge
0 1 2 3 4 nipple discharge
0 1 2 3 4 sexual dysfunction

Lifestyle

What is your work? _____

Do you enjoy your work? Yes / No Why?_____

What is your daily diet like?_____

_____

_____

_____

Amount of caffeine? _____ Alcohol?_____

Do you smoke? Yes / No Have a history of smoking? Yes / No How much?_____

Other drug use (current or past)? _____

Do you exercise? Yes / No Type and frequency? _____

_____

Do you sleep well? Yes / No How many hours/night? _____

Do you wake feeling rested? Yes / No

Do you have someone with whom you can really talk? Yes / No

What do you do to relax? _____

_____

_____

_____

How is your home life? _____

_____

_____

What in your life promotes your health? _____

_____

_____

_____

What in your life compromises your health?_____

_____

_____

_____

Is there anything else you would like me to know? _____

_____

_____

_____

_____