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Health History Questionnaire **Date: _____**

Patient's Name (Last, First, M.I.)	**DOB (mm/dd/yyyy) Sex (M/F)			Patient Status: ☐Single ☐Married ☐Other ☐Employed ☐F-time ☐P-time ☐Student ☐F-time ☐P-time
Patient's Address (Street)	Relation to Insured			Patient's Employer
City State	Zip Code	Home Phone (10 digit)		Work Phone
Insured's Name (Last, First, M.I.)	**DOB (mm/dd/yyyy) Sex (M/F)			Insured's Social Security Number:
Insured's Address (Street)	Phone (10 digit)			Insured's Employer
City State	Zip Code	Insured's Claim # or ID #		Group ID #
Insurance Company		Plan Name or Program		
Billing Address		Who Referred You?		
Patient's E-mail Address	Onset/Injury Date	Work Related (Y/N) Auto Accident (Y/N) U.S. State		

What is your main complaint today? _____

_____

When did this problem begin? (please be specific) _____

_____

What do you think caused it? Is the cause still present? _____

_____

What treatments have you tried already? What were the results? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

To what extent does this problem interfere with your daily activities? (work, sleep, eating, sex…) _____

_____

How severe is your problem right now? (please mark the scale below)

No Problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (please mark the scale below)

No Problem Moderate Worst Imaginable

Patient Name: _____ **Date:** _____

Your Past Medical History (please indicate with date (s):

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

Surgeries (type and date): _____

_____

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

_____

Significant Dental Work (type and date): _____

_____

Birth History (prolonged labor, forceps delivery, caesarian section, other): _____

_____

(How) Do You Take Care of Your Spirit? _____

_____

Family Medical History (other family members beside yourself):

☐ High Blood Pressure	☐ Stroke	☐ Diabetes	☐ Allergies (other family): _____
☐ Heart Disease	☐ Alcoholism	☐ Cancer: _____	
☐ Arteriosclerosis	☐ Seizures	_____	
	☐ Asthma	_____	

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

_____

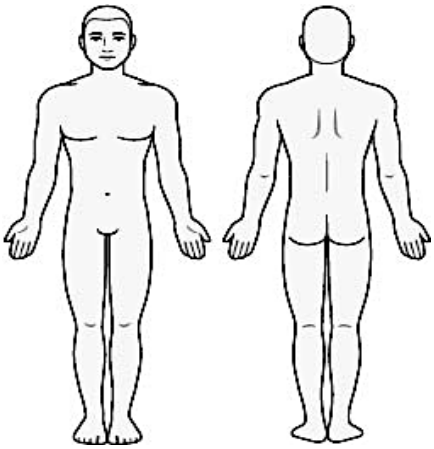
Do you exercise regularly? Y or N Please describe: _____

_____

Comments (please list any other problems you would like to discuss): _____

_____

Indicate Painful of Distressed Areas



What are Your Treatment Goals?

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

Patient Name: _____ Date: _____

Please check any box of symptoms you have had in the past 2 weeks.

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
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesions
- ☐ 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
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ 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 feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty 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: _____

# of premature births: ___

# of miscarriages: _____

# of abortions: _____

Age at first menses: _____

Length of full cycle: _____

Length of menses: _____

Last menses start date: __

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ irregular periods
- ☐ Change 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

	Excessive	Moderate	Minimal	None	Please add comments where significant
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Tea	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	
Sleep	☐	☐	☐	☐	
Appetite	☐	☐	☐	☐	
Energy Level	☐	☐	☐	☐	
Medication	☐	☐	☐	☐	
Vitamins	☐	☐	☐	☐	
Food Intake	☐	☐	☐	☐	
Teeth Problems	☐	☐	☐	☐	
Drugs	☐	☐	☐	☐	
Salt Intake	☐	☐	☐	☐	
Other	☐	☐	☐	☐	
Stress level	☐	☐	☐	☐	

Diet (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 start/stop dates: _____
_____

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

What allergies do you have? What reactions do you have to these chemicals, foods, drugs, animals, etc.? ____
_____

Local person to call in case of an emergency? Relative, friend, neighbor? _____
_____