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Patient Name:_________________________

Date:_________________________________

Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

Please identify the health concerns that brought you to the Clinic in order of importance below:

Condition	For how long?	Past treatment that helped this condition
1. ____________________________	______________	____
2. ____________________________	______________	____
3. ____________________________	______________	____

List any foods, drugs, or medications you are hypersensitive or allergic to:

____

List any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking and for what condition they are being taken:

____

____

Height: ____________Current weight: _________

Blood Pressure: What is your most recent blood pressure reading? ____/____When was this reading taken? ________

Childhood & adulthood major illnesses, accidents, hospitalizations, surgeries:

Event	Date	Event	Date
____		____	
____		____	
____		____	

Family Medical History
(immediate blood relatives)

☐ Allergies__________________	☐ Diabetes	☐ Alcoholism
☐ Arteriosclerosis	☐ Seizures	☐ High Blood Pressure
☐ Cancer_____________________	☐ Asthma	☐ Autoimmune disease_____________________________
☐ Heart Disease	☐ Stroke	☐ Emotional/Psychological Disorder_________________
		☐ Other____

SYMPTOM LIST

Please put a 'C' next to symptoms that you have currently and 'P' next to those you have experienced in the past.

Emotional/Psychological

- ◻ Anxiety
- ◻ Depression
- ◻ Manic
- ◻ Bipolar
- ◻ Stress
- ◻ Frequent irritability
- ◻ Frequent anger
- ◻ Mood swings
- ◻ Anorexia
- ◻ Bulimia
- ◻ Frequent Worry
- ◻ Obsessive/Compulsive
- ◻ Chronic sadness/grief
- ◻ Overly fearful
- ◻ Addictions: (to what?):______________

Immune& Inflammation

- ◻ Chronic Fatigue Syndrome
- ◻ Hashimoto's disease
- ◻ Grave's disease
- ◻ Arthritis________________
- ◻ Lupus
- ◻ Colitis
- ◻ Crohn's disease
- ◻ Fibromyalgia
- ◻ Frequent illness
- ◻ Frequent infection
- ◻ Hay fever
- ◻ Frequent swollen glands
- ◻ Cancer
- ◻ Hepatitis A, B or C
- ◻ Herpes
- ◻ Chicken pox
- ◻ HIV
- ◻ Cold sores
- ◻ Mononucleosis
- ◻ Raynaud's Syndrome
- ◻ Connective tissue inflammation
- ◻ Food allergies
- ◻ Environmental allergies
- ◻ Seasonal allergies

Eyes, Ears, Nose, Throat & Head

- ◻ Impaired vision
- ◻ Blurry vision
- ◻ Eye pain/strain
- ◻ Glaucoma
- ◻ Dry eyes
- ◻ Red & painful eyes
- ◻ Watery eyes
- ◻ Impaired hearing
- ◻ Ear ringing
- ◻ Earaches
- ◻ Nose bleeds
- ◻ Bleeding gums
- ◻ Runny nose
- ◻ Sinus problems
- ◻ Snoring
- ◻ Headaches
- ◻ Teeth grinding
- ◻ Teeth grinding
- ◻ Toothache
- ◻ TMJ/Jaw problems
- ◻ Sore throat
- ◻ Dry mouth
- ◻ Dry throat

Gastrointestinal & Elimination

- ◻ Ulcers
- ◻ Increased appetite
- ◻ Decreased appetite
- ◻ Nausea/Vomiting
- ◻ Gas
- ◻ Abdominal pain
- ◻ Liver disease
- ◻ Heartburn/Acid reflux
- ◻ Belching
- ◻ Rectal bleeding
- ◻ Hemorrhoids
- ◻ Indigestion
- ◻ Constipation
- ◻ Loose stools
- ◻ Diarrhea
- ◻ Irritable bowel
- ◻ Inflammatory bowel
- ◻ Polyps
- ◻ Leaky gut
- ◻ Greasy foods upset
- ◻ Bloating after meals
- ◻ Discomfort after eating
- ◻ Discomfort relieved by eating
- ◻ Gallstones/Gallbladder disease

___# of Bowel movements per day

Please circle type of BM:
loose hard dry soft sticky (sticks to bowl) "normal"

Please circle color of BM:
brown pale color green black bloody

Cardiovascular & Blood

- ◻ Irregular heartbeat
- ◻ Palpitations/Fluttering
- ◻ Chest pain
- ◻ Anemia
- ◻ Dizziness
- ◻ TIA/Stroke
- ◻ Heart murmurs
- ◻ Rheumatic Fever
- ◻ High LDL cholesterol
- ◻ Low HDL cholesterol
- ◻ High blood pressure
- ◻ Low blood pressure
- ◻ Cold hands/feet
- ◻ Hands & feet go to sleep easily
- ◻ Chest pressure or tightness
- ◻ Fast pulse (over 100 beats/min)
- ◻ Slow pulse (under 60 beats/min)
- ◻ Swelling of ankles
- ◻ Heart disease
- ◻ Heart attack
- ◻ Numbness
- ◻ Varicose veins

Endocrine

- ◻ Thyroid problems
- ◻ Diabetes Mellitus
- ◻ Hypoglycemia
- ◻ Feeling hot or cold
- ◻ Hypo adrenal

Neurological

- ◻ Seizures/Epilepsy
- ◻ Nerve pain/inflammation
- ◻ Vertigo/Dizziness
- ◻ Paralysis
- ◻ Numbness/Tingling
- ◻ Loss of Balance

Respiratory

- ◻ Pneumonia
- ◻ Frequent colds & flu
- ◻ Wheezing
- ◻ Bronchitis
- ◻ Shortness of breath
- ◻ Persistent cough
- ◻ Pleurisy
- ◻ Asthma
- ◻ Tuberculosis
- ◻ Emphysema

Sleep & Energy

- □ Insomnia
- □ Light sleeper/wake easily
- □ Can’t fall back to sleep
- □ Fatigue
- □ Tired during day but awake at night
- □ Can’t relax
- □ Poor memory
- □ Fuzzy thinking

Skin

- □ Rashes
- □ Eczema
- □ Hives
- □ Dandruff
- □ Fungal infections
- □ Warts
- □ Psoriasis
- □ Sweat easily during day
- □ Sweat easily at night
- □ Never sweat
- □ Itchy skin
- □ Dry skin
- □ Bruise easily

Kidneys & Urinary Tract

- □ Kidney disease
- □ Painful urination
- □ Frequent urinary tract infection
- □ Frequent urination in general
- □ Frequent urination at night
- □ Lack of bladder control
- □ Kidney stones
- □ Impaired urination
- □ Blood in urine

Blood Sugar Regulation

- □ Emotional eating
- □ Excessive appetite
- □ Hungry between meals
- □ Irritable before meals
- □ Get shaky if hungry
- □ Afternoon headaches
- □ Crave sweets in afternoon
- □ Compulsive eating
- □ Frequent dieting
- □ Frequent overeating

Women

- □ PMS symptoms
- □ Irregular/missed periods
- □ Painful periods
- □ Short cycles (<26 days)
- □ Long cycles (>35 days)
- □ Clots in menstrual blood
- □ Fatigue after menses
- □ Spotting between periods
- □ Difficulty conceiving
- □ Pregnant now

_________ **Date of last period**

___# **Days of bleeding**

Color of blood:
bright dark pale

Type of blood:
light medium heavy

- □ Current or past sexual or physical abuse
- □ Sexually transmitted disease
- □ Pain with intercourse

Current method of birth control:

____

Past methods of birth control:

____

___# of Pregnancies
___# of Births
___# of Miscarriages
___# of Abortions

Note any complications during pregnancies, births, postpartum:

____

- □ Vaginal discharge
- □ Vaginal infections
- □ Breast fibroids
- □ Breast lumps
- □ Nipple discharge
- □ Uterine fibroids
- □ Endometriosis
- □ Ovarian Cyst
- □ Hysterectomy, when: _______

Monthly breast exam? Y N
Last Pap Smear: _______________
Last mammogram: ____________

- □ Cancer: ovarian uterine breast cervical
- □ Menopause symptoms
- □ Hormone Replacement Therapy
- □ Decreased sexual energy
- □ Increased sexual energy

Men

- □ Prostate hypertrophy (BPH) /cancer
- □ Testicular pain/swelling
- □ Difficulty conceiving
- □ Penile discharge
- □ Increased sexual energy
- □ Decreased sexual energy
- □ Sexual difficulties
- □ Current past sexual or physical abuse
- □ Sexually transmitted diseases

Musculoskeletal

Note any current joint, muscle, tendon, or ligament problems. Include
1) Cause, 2) Diagnosis, 3) When problem started, 4) Treatment that’s helped:

____
____
____
____
____

Note any past major musculoskeletal problems or injuries:
____
____
____

Is there anything else we should know?____

Lifestyle:

- ◻ Do you typically eat at least three meals per day? Y N If no, how many? ____________
- ◻ Exercise routine: ____
- ◻ Spiritual practice: ____
- ◻ How many hours per night do you sleep? ________ Do you wake rested? Y N
- ◻ Level of education completed: High School Bachelors Masters Doctorate Other
- ◻ Occupation: ________________________ Employer: ____________________ Hours/Week: _______

  Do you enjoy work? Y/N Why/Why not? ____
- ◻ Nicotine/Alcohol/Caffeine Use: ____
- ◻ Have you experienced any major traumas? Y N Explain: ______________________
- ◻ How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
- ◻ Television habits: ______________________ Reading habits: ____________________
- ◻ Interests and hobbies: ____
- ◻ How did you hear about us? ____

Thank You!!

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