HEALTH HISTORY FORM

Please use back of this form or additional pages for any additional space needed or additional info you may wish to provide; ALL is confidential.

Name____ Birthday_____________ Age_______ Gender___________

Address____ City_______________________ State_______ Zip__________

Home Phone_________________ Cell Phone_______________ [*send/receive texts?*____] Work Phone_______________
(Please indicate preferred contact number)

Email____ Height_____________ Weight_________________

Married Single Partner Divorced/Separated Widowed Children (Age & Gender)_________________________

Family Physician__________________________ Phone_____________________ Referred by_______________________
(No contact will be made without your permission)

Emergency Contact__________________________ Phone___________________ Relationship_____________________

Wellness Goals: *What health concerns / goals would you like to address through treatment?*

____

____

____

Nutrition:
Please describe any special diet or food restrictions to which you adhere (e.g. Gluten-free, Vegan, Low Carb, etc.):

____

What do you eat on a "typical" day & please give approximate time(s) of day?

Breakfast____ Lunch____

Dinner____ Snacks ____

Foods Cravings:_____________________________ Preferred Beverage Temperature: □ Hot □ Room Temp. □ Cold

Medications / Supplements:
Please include any Rx medicine, vitamin, supplement, herbal, hormone, laxative, homeopathic, or over the counter medicine you take on a regular basis & for what condition (with dosage & brand, if known): ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Allergies *(environmental, animal, medication, chemical, food)*: ____

Lifestyle:
What is your occupation?______________________________________ How many hours do you work weekly?_________
How many servings per day (or per week/month) do you use of the following?
*water*___________ *coffee (caf/decaf)* ___________ *tea (caf/decaf)* ___________ *soft drinks (reg/diet)*___________ *alcohol*____________
*cigarettes/tobacco*______________ *drug use (recreational)*________________

What time do you typically fall asleep?______________ Wake up?____________ Feel rested when wake? __________

Please describe your current exercise regimen: □ No Exercise OR Exercise activities & hours/wk for each:

____

____

Favorite: Time of Day? _____________ Season? ____________ Climate? _____________ Color? _____________ Taste? _____________

Do you have a known history of any exposure to toxic substances? □ Yes □ No

Have you traveled internationally? □ Yes □ No Treated for: □ Parasites □ Malaria □ Dysentery □ Dengue Fever □ N/A

Hospitalization/Surgical History: *Please list dates of hospitalizations & major surgeries & describe the treatment or procedure.*

____Date__________
____Date__________
____Date__________

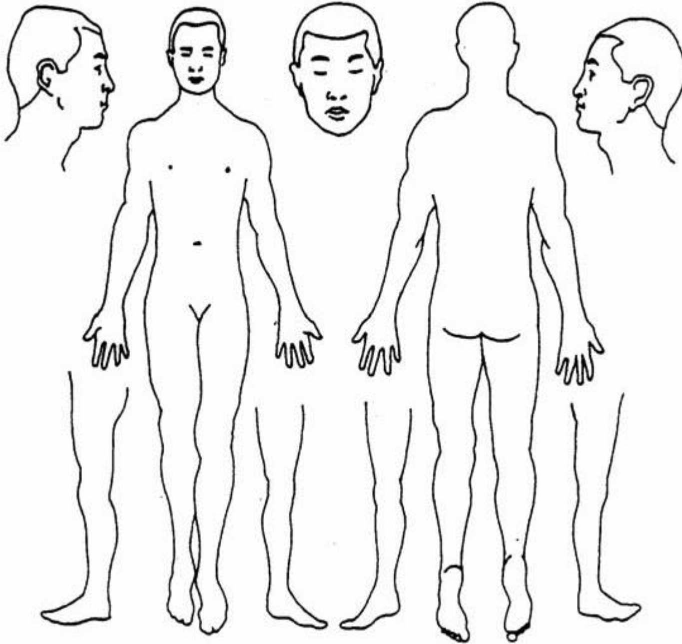
For Women: *Please indicate the dates for any of the below:*

Last Pap Smear______ Last Mammogram______ Tubal Ligation_______ Hysterectomy______ Ectopic Pregnancy______

Are you currently pregnant or trying to conceive? □ Yes □ No □ Unsure Start & End of Last Menses______________

Indicate number of occurrences: Live Births_______ Pregnancies_________ Miscarriages________ C-Sections_______

Muscular-Skeletal or Other Pain:



Do you experience pain or discomfort in any area of your body? □ Yes □ No

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

Do you have any difficulty with:
□ Walking □ Sitting □ Standing □ Driving □ Other

Please list any accidents, injuries, broken bones or scars *(draw arrows to models on left if needed)*: ____________
____
____
____
____

For any discomfort issues noted above, please describe any patterns you may have noticed (e.g., when it first started; time of day/month/year that it comes/goes now) as well as the Frequency (e.g., how often per day/mo/yr), Intensity (1-10 scale, with 10 the greatest intensity), and Duration (e.g., mins/hrs/days) of the discomfort. If needed, add numbers to or draw arrows from an above issue to connect to its corresponding details in below table:

ISSUE	*WHEN STARTED*	*WHEN OCCURS NOW*	*FREQUENCY*	*INTENSITY (1-10)*	*DURATION*
1.					
2.					
3.					
4.					
5.					

General Health & Social History: *Please give a few words or a single sentence to describe yourself and your overall health during each of the following phases of your life:*

Birth to Infancy: ____

Grade to High School / College: ____

Adult (~18-30yr): ____

Now (if >30yr): ____

Medical History Part I:

Condition	Self (date diagnosed)	Mother	Father	Sibling(s)	Grandparent (maternal/paternal)	Spouse / Partner	Children
Good health overall							
Adopted							
Age Deceased	NA						
Arthritis							
Asthma							
Blood or bleeding disorders/anemia							
Cancer or Tumors							
Diabetes							
Depression or Mental Illness							
High BP/Heart Disease/Stroke							
Seizures							
Substance abuse/dependency							
Thyroid Disorders							

Medical History Part II: *Please mark ANY that apply to you, and CIRCLE ITEMS as needed to differentiate:*

GENERAL

Past	Current	Condition
[ ]	[ ]	Change in appetite
[ ]	[ ]	High/Low appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Strong Thirst
[ ]	[ ]	Bleed/ bruise easily
[ ]	[ ]	Decreased Libido

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Pacemaker
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: ___________________

FEMALE

Past	Current	Condition
[ ]	[ ]	Bladder/ urinary tract infections
[ ]	[ ]	Yeast or bacterial vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Ovarian Cysts
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Endometriosis
[ ]	[ ]	Uterine Fibroids
[ ]	[ ]	Vaginal Dryness
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps/ tenderness

SKIN & HAIR & NAILS

Past	Current	Condition
[ ]	[ ]	Hair Loss
[ ]	[ ]	Weak/Brittle Nails
[ ]	[ ]	Dandruff
[ ]	[ ]	Rashes /Hives
[ ]	[ ]	Fungal Infections
[ ]	[ ]	Itching
[ ]	[ ]	Eczema/Psoriasis
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors / Lumps

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	COPD
[ ]	[ ]	Shortness of Breath
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _______________

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Vertigo
[ ]	[ ]	Confusion
[ ]	[ ]	Poor Memory or Attention
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Loss of balance/coordination
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: ___________________

HEAD & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Migraines
[ ]	[ ]	Facial Pain
[ ]	[ ]	Other: ______________

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain on urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Incontinence
[ ]	[ ]	Dribbling/Leaking
[ ]	[ ]	Other: ________________

PSYCHOLOGICAL / EMOTIONAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / Stress / Worry
[ ]	[ ]	Irritability / short temper
[ ]	[ ]	Treated for emotional or Psychological problems
[ ]	[ ]	Compulsive Behavior
[ ]	[ ]	Suicidal Thoughts
[ ]	[ ]	Other: _______________________

EARS

Past	Current	Condition
[ ]	[ ]	Infection or Pain
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____________

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots /Floaters
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye dryness/ itching
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Glaucoma

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Mouth/Tongue Sores
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	TMJ
[ ]	[ ]	Difficulty swallowing
[ ]	[ ]	Other: _____________

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Loose Stools
[ ]	[ ]	Bloating/Distension
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Intestinal pain or cramps
[ ]	[ ]	Indigestion/ Reflux
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas /Flatulence
[ ]	[ ]	Undigested food in stools
[ ]	[ ]	Other: _______________

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Erectile Dysfunction
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Prostate Issue
[ ]	[ ]	Other: _______________

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Osteoarthritis
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain
[ ]	[ ]	Rheumatoid arthritis
[ ]	[ ]	Other: _____________________

SLEEP DISTURBANCES

Past	Current	Condition
[ ]	[ ]	Difficulty falling or staying asleep
[ ]	[ ]	Excessive Dreams or Nightmares
[ ]	[ ]	Sleep apnea / snoring
[ ]	[ ]	Other:______________________

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	TB (Tuberculosis)
[ ]	[ ]	Hepatitis/other Liver Disorder
[ ]	[ ]	Mononucleosis
[ ]	[ ]	Blood Transfusion
[ ]	[ ]	STD: ______________________
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral (cold sores)
[ ]	[ ]	Herpes: genital
[ ]	[ ]	Other: _____________________

Based on your life experiences to date and your way of being in the world, please tell me in a few words or single sentence what you feel is your overall greatest Strength(s) and greatest Challenge(s):

STRENGTH(S):____

____

CHALLENGE(S):____

____

Do you have any additional concerns you would like to discuss?

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Patient Signature: ________________________________ ***Date:*** ____________