HEALTH HISTORY

Name_____ Date_____

Address_____

City, Zip_____ (H) Phone_____

Email_____ (W or C) Phone_____

Job Position_____ D.O.B._____/_____/_____ Sex_____ Number of Children_____

Marital Status □ Single □ Partner □ Married □ Separated □ Divorced □ Widow(er)

Are you recovering from a cold or flu?_____ Are you pregnant? Y N

Reason for office visit:

1_____ Date condition began_____

2_____ Date condition began_____

3_____ Date condition began_____

List any health problems you are currently being treated:

_____

_____

_____

What types of therapies have you tried for these problems or to improve your health overall:

□ diet □ fasting □ vitamin/minerals □ herbs □ homeopathy □ chiropractic □ acupuncture □ conventional drugs

□ other_____

Do you experience any of these general symptoms EVERY DAY?

□ Panic attacks	□ Shortness of breath	□ Insomnia	□ Constipation	□ Chronic pain/Inflammation	□ Bleeding
□ Depression	□ Debilitating fatigue	□ Nausea	□ Fecal Incontinence	□ Poor wound healing	□ Discharge
□ Dizziness	□ Disinterest in sex	□ Vomiting	□ Urinary Incontinence	□ Low grade fever	□Itching/rash

Laboratory procedures performed (blood, stool, urine, etc.)_____

Outcome_____

_____

Major Hospitalizations, Surgeries, Injuries. Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (eg, work, finances, relationship(s), etc)_____

What is your overall energy level on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Do you sleep through the night? Y N Do you wake rested? Y N

Do you consider yourself: □ underweight □ overweight □ just right

Your weight today_____lbs Your weight at age 20_____lbs Your ideal weight_____lbs

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? Y N

How committed are you to making a change in your health (1 = least, 10 = most committed): 1 2 3 4 5 6 7 8 9 10

Do you tend to be sensitive to medications? □ Yes □ No

HEALTH HISTORY **continued**

Current medications (prescriptions or over-the-counter):

_____

_____

_____

List any known allergies:

_____

List any known drug allergies:

_____

Check all that Apply

□ Arthritis
□ Allergies/hay fever
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune disease
□ Blood pressure problems
□ Bronchitis
□ Cancer
□ Chronic fatigue syndrome
□ Carpal tunnel syndrome
□ Chest pain
□ Cholesterol, elevated
□ Circulatory problems
□ Dental problems
□ Depression
□ Diabetes
□ Diverticular disease
□ Drug addiction
□ Eating disorder
□ Epilepsy/seizures
□ Emphysema
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Gastroesophageal reflux disease
□ Genetic disorder
□ Glaucoma
□ Gout
□ Heart disease
□ Infection, chronic
□ IBD/colitis
□ Irritable bowel syndrome
□ Kidney or bladder disease
□ Liver or gallbladder disease (stones)
□ Mental illness
□ Migraine headaches
□ Neurological problems (Parkinson's, paralysis, etc)
□ Stroke
□ Thyroid problems
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually transmitted disease
□ Skin problems
□ Tuberculosis
□ Ulcer
□ Urinary tract infection
□ Varicose veins
Other _____

Medical (Women)

□ Menstrual irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic breasts
□ Fibroid/ovarian cysts
□ PMS (premenstrual syndrome)
□ Breast cancer
□ Pelvic inflammatory disease
□ Vaginal infections
□ Decreased sex drive
□ Menopause
□ Surgical Menopause
□ C-section. How many____
PAP □ + □ –
Mammogram □ + □ –
Number of pregnancies_____
Number of children_____
Age of first period_____
Date of last period_____
Length of cycle____days
Any recent changes in menstrual flow(eg. Heavier, more clots, etc)

_____

Medical (Men)

□ Benign prostatic hyperplasia
□ Prostate cancer
□ Decreased sex drive
□ Infertility

Family Health History (Parents and Siblings)

□ Arthritis
□ Asthma/lung disease
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune disease
□ Cancer
□ Depression
□ Diabetes
□ Drug addiction
□ Eating disorder
□ Genetic disorder
□ Glaucoma
□ Heart disease
□ Hypertension
□ Infertility
□ Mental illness
□ Migraine Headaches
□ Obesity
□ Osteoporosis
□ Stroke
Other_____

Health Habits

□ Smoke
□ Use alcohol
□ Caffeine (coffee, pop, etc)
Glasses of water/day_____

_____

Hours of sleep/night_____

_____

Number of stools/day_____

_____

Consistency of stools:
□ Hard □ Soft □ Marbles
□ Normal □ Other

Exercise

□ none
□ 1 to 2 days per week
□ 3 to 4 days per week
□ 5 to 7 days per week
□ Less than 45 minutes per workout
□ More than 45 minutes per workout

Nutrition & Diet

□ Mixed food diet (animal and vegetable sources)
□ Vegetarian
□ Vegan

Eating Habits

□ One meal per day
□ Two meals per day
□ Three meals per day
□ Graze (small frequent meals)
□ Eat constantly whether hungry or not

I Would Like To:

□ Feel more vital
□ Feel less pain
□ Lose weight
□ Improve memory
□ Be less indecisive
□ Increase sex drive
□ Use less medications
□ Have more endurance
□ Sleep better
□ Be stronger
□ Be less moody
□ Feel more motivated
□ Increase muscle tone
□ Slow down aging