Male Health History Questionnaire

(To be completed by patient)

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Name:_____ Date:_____

Address _____ City _____ State ___ Zip Code_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Gender: Female__Male___

Referred by:

Name, address, & phone number of primary care physician:

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Occupation _____ Hours per week _____ Retired

Nature of Business _____

Height:_____ Weight:_____

What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time that you felt well?

What seems to trigger your symptoms?

What seems to worsen your symptoms?

What seems to make you feel better?

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

How much time have you lost from work or school in the past year due to these conditions?

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When was the last time that you felt well?

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What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

How much time have you lost from work or school in the past year due to these conditions?

What injuries have you had in the past?

What diagnostic studies or test have you had and the outcome?

List hospitalizations and why

List your medications as a child

List your medications as an adult

List any vitamins and minerals you are taking

What was your childhood diet like?

Review of Systems, check all that apply

GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Sleepwalker
- ❑ Nightmares
- ❑ No dream recall
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted vision

SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rashes
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer

- ❑ Strong body odor

Is your skin sensitive to:
- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

HEAD:
- ❑ Poor Concentration
- ❑ Confusion
- ❑ Headaches:
- ❑ After Meals
- ❑ Severe
- ❑ Migraine
- ❑ Frontal
- ❑ Afternoon
- ❑ Occipital
- ❑ Afternoon
- ❑ Daytime
- ❑ Relieved by:
- ❑ Eating Sweets
- ❑ Concussion/Whiplash
- ❑ Mental sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face twitch
- ❑ Poor memory
- ❑ Hair loss

EYES:
- ❑ Feeling of sand in eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ See bright flashes
- ❑ Halo around lights
- ❑ Eye pains
- ❑ Dark circles under eyes
- ❑ Strong light irritates
- ❑ Cataracts
- ❑ Floaters in eyes
- ❑ Visual hallucinations

EARS:
- ❑ Aches
- ❑ Discharge/Conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/Hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing hallucinations

NOSE/SINUSES
- ❑ Stuffy
- ❑ Bleeding

- ❑ Running/Discharge
- ❑ Watery nose
- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell
- ❑ Do the change of seasons tend to make

your symptoms worse? Yes/No

If yes, is it worse in the:

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

MOUTH:

- ❑ Coated tongue
- ❑ Sore tongue
- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Canker sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

THROAT:

- ❑ Mucus
- ❑ Difficulty swallowing
- ❑ Frequent hoarseness
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to hot
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/Feet go to sleep/numbness/tingling
- ❑ High blood pressure
- ❑ Chest pain
- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting spells
- ❑ High cholesterol

- ❑ High triglycerides
- ❑ Wheezing
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently sighing
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Varicose veins/spider veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Prior heart attack ? When___/___/_____
- ❑ Phlebitis

GASTROINTESTINAL

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous stomach
- ❑ Full feeling after small meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowels
- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Rectal itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Night time urination
- ❑ Problem passing urine

- ❑ Kidney pain
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

MEN'S HISTORY (for men only)

Have you had a PSA done?

Yes _____ No _____

PSA Level:

- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10

- ❑ Prostate enlargement
- ❑ Prostate infection
- ❑ Change in libido
- ❑ Impotence
- ❑ Diminished/poor libido
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining an erection
- ❑ Nocturia (urination at night)
- ❑ How many times at night? ____
- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of bladder control

JOINT/MUSCLES/TENDONS

- ❑ Pain wakes you
- ❑ Weakness in legs and arms
- ❑ Balance problems
- ❑ Muscle cramping
- ❑ Head injury
- ❑ Muscle stiffness in morning
- ❑ Damp weather bothers you

EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts/Amnesia
- ❑ Had prior shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Startled by sudden noises
- ❑ Anxiety/Feeling of panic
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless/groggy
- ❑ Withdrawn feeling/Feeling 'lost'
- ❑ Had nervous breakdown
- ❑ Unable to concentrate/short attention span

- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person by others
- ❑ Tends to worry needlessly
- ❑ Unusual tension

EMOTIONAL (CONTINUED)

- ❑ Frustration
- ❑ Emotional numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Previously admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Misunderstood by others
- ❑ Irritable
- ❑ Feeling of hostility/volatile or aggressive
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs
- ❑ Been addicted to drugs
- ❑ Extremely shy

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

How much of the following do you consume each week?

Candy
Cheese
Chocolate
Cups of coffee containing caffeine
Cups of decaffeinated coffee or tea
Cups of hot chocolate
Cups of tea containing caffeine
Diet soda
Ice cream
Salty foods
Slices of white bread (rolls/bagels,
Soda with caffeine
Soda without caffeine

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe)

Please tell us if there is anything special about your diet that we should know.
Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc? Yes___ No____
If yes, are these symptoms associated with any particular food or supplement? Yes___ No____
If yes, please name the food or supplement and symptom(s).
Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

High fat foods high protein foods high carb foods (breads/pasta)

Refined sugar (junk food) fried food alcohol drinks

Do you feel **better** when you eat a lot of:

High fat foods high protein foods high carb foods (breads/pasta)

Refined sugar (junk food) fried food alcohol drinks

Does skipping meals greatly affect your symptoms? Yes _____ No _____
Has there ever been a food that you have craved or 'binged' on over a period of time?
Yes _____ No _____ If yes, what food(s) _____
_____
Do you have an aversion to certain foods? Yes _____ No _____
If yes, what food(s) _____
_____

Circle which applies to your bowel movements

More than 3x/day
1-3x/ day
4-6x/week
2-3x/week
1 or fewer x/week
Dark brown consistently
Medium brown consistently
Very dark or black
Greenish color
Blood is visible
Varies a lot

Consistency	√
Soft and well formed	
Often floats	
Difficult to pass	
Diarrhea	

	√
Yellow, light brown	
Greasy, shiny appearance	

Thin, long or narrow
Small and hard
Loose but not watery
Alternating between hard and loose

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____
If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____
Have you ever had a problem with alcohol? Yes____ No____
If yes, indicate time period (month/year) From_____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____
If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____
_____
To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___
If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you have trouble falling asleep

Do you use sleep aids

Feel rested upon waking

Have insomnia, now or ever

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____
Do you feel you can easily handle the stress in your life? Yes ____ No
If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____
If yes, do you believe that you know the source of your stress? Yes____ No____
If yes, what do you believe it to be?
Have you ever contemplated suicide? Yes____ No____
If yes, how often? When was the last time?
Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)
Did it help?

Have you ever been involved in abusive relationships in your life? Yes ___ No___
Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes__ No___
Did you feel safe growing up? Yes ___ No___

Is there anything that you would like to discuss with the doctor today that you feel was not covered on this form? Yes_____ No_____
Comments _____
_____
_____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:
Significantly modify your diet 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g. work demands, sleep habits) 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.
We look forward to helping you achieve lifelong health and wellbeing.
Yours in Health

Drs. Jason & Kimberly Stephenson

I understand that Nutritional counseling/Applied kinesiology is an assessment system and it is used to assist the practitioner and help the patient improve his/her physical state through nutritional and life style recommendations. I also, understand that it is to assist the practitioner in establishing and monitoring patient nutritional progress. I understand that Nutritional counseling/Applied kinesiology procedures do not diagnose or treat any disease or physical illness. I understand that Nutritional counseling/Applied kinesiology does not replace standard laboratory or other clinical diagnostic tools or procedures, and in themselves do not treat anything. I specifically authorize Stephenson Chiropractic & Wellness Center, P.C. to develop a natural, complementary health improvement program based on the information I have given the doctor for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or “cure” of any disease. I understand that this is not a method for “diagnosing” or “treating” of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, so that safe natural programs can be

developed for the purpose of bringing about a more optimum state of health. I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success. I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered to me will be immediately due and payable, and to agree to arbitration for any disputes. I Understand that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision. To wave the right of notice or exemption within the state of Alabama or any other state in regard to personal property, allows one and one half (1.5 %) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

Patient name (Please print)_____ Patient signature_____ Date M/D/Y_____

Witness name (Please print)_____ Witness signature_____ Date M/D/Y_____