Healing Arts Medical

Confidential Health Questionnaire

Name: _____Today's Date: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ Gender: _____ Referred by:_____

What are your health concerns? Please indicate date of onset.

_____

_____

_____

_____

_____

What would you like to learn/gain from this consultation? _____

_____

Are you currently taking any vitamins/supplements/minerals/herbs/homeopathic remedies, prescription/non-prescription medications? Please list including name, dosage and frequency. For non-prescription products please include the brand (Please write on separate sheet if you need more space):

_____

_____

_____

_____

Do you have any known **allergies**? Yes / No, If Yes, please list and include what type of reaction, (rash, swelling, etc.)

_____

_____

Past Medical History: Please list all significant past and ongoing medical issues for which you have sought medical care (please include date of onset):

_____

_____

_____

Please list any surgeries, accidents, injuries or childhood diseases you have had. Please include the dates:

_____

_____

_____

Social History

Occupation: _____ How many hours do you work per week? _____

Relationship Status (circle): Single Married Separated Divorced With Partner Widow(er)

Children? _____ Pets? _____

Do you sleep well?_____How do you feel when you wake up? _____

Do you sleep mostly on your: BACK RIGHT SIDE LEFT SIDE STOMACH MOVE ALL OVER

Do you drink caffeinated drinks? _____ How much & how often? _____

Do you use tobacco products? _____How long and how much? _____

Do you drink alcohol? _____ How much & how often? _____

Height: _____ Current Weight: _____Do you feel well at this weight? _____

What role does exercise play in your life? _____

How much water do you drink per day? _____

Are your bowels regular? _____ Any issues with urination? _____

How would you rate the amount of stress in your life 1(low)-10(High)_____

How do you manage your stress?_____