G L E N V I E W H E A L I N G A R T S C E N T E R
H E A L T H Q U E S T I O N A I R E

Name _____Today's Date _____

Address _____ City_____ State_____ Zip_____

Phone: Home_____ Work_____ Cell_____

Birth date _____ Age _____ Ht _____ Wt _____ Sex_____

Marital Status _____ No. of Children _____ Occupation_____

E-mail address_____ Referred by_____

Emergency Contact _____ Relationship_____

Their Phone Numbers _____ Their Address _____

Primary Care Practitioner:_____

What are the main problems you would like us to help you with?

When and how did they develop?

Have you ever had a similar problem before? ____yes ____no
If yes, please explain:

Have you been given a diagnosis for this problem? ____yes ____no
If yes, what was the diagnosis?

Have you received treatment for this problem? ____yes ____no
If yes, when and by whom?

What were the results of this treatment?

Have you experienced any injuries related to this problem? ____yes ____no
If yes, please explain:

What makes the problem better or worse?

List additional physicians you are seeing:

To what extent does this problem interfere with your: (0=not at all, 5=greatly)

___home life ___work life ___social life ___ability to exercise ___rest/sleep ___other

Please explain:

Occupational stress? (Please circle) chemical physical psychological

Please explain:

Where do you work? ____ indoors _____outdoors

Average Daily Diet:

Types and amount of liquid intake per day?

Do you skip any meals? If so, please explain.

Are you now or ever been on a (physician or self prescribed) restricted diet?
(i.e., diabetic, vegetarian, high protein, low carbohydrate) If so, what kind?

Habits:

Do you exercise? If so, how much and what kind?

Do you smoke? If so, what do you smoke and how much?

Medicines taken within the last two months (including pharmaceuticals, vitamins, over the counter drugs or herbs)

Do you have Allergies (drugs, chemicals, foods, substances)? Types of reaction?

How many hours do you sleep on average?_____ From_____ to _____

Past Medical History (please include when the diagnosis was established)
Significant Illness:

____Cancer ____Diabetes ____Hepatitis ____Thyroid Disease ____Heart Disease
____Fibromyalgia ____Arthritis ____Tuberculosis ____ Hypertension ____Anemia
____Emotional Imbalance ____Breathing Problems ____Allergies ____Seizures
____Digestive Disorders ____HIV/AIDS ____Venereal Disease _____Other-explain

Family Medical History (please specify family member)

_____Cancer _____Diabetes _____Hepatitis _____Hypertension
_____Heart Disease _____Stroke _____Asthma _____Allergies
_____Auto-Immune _____Alcoholism _____Miscarriage _____Other

Injuries- List all serious injuries and dates they occurred:

Surgeries- List all surgeries and date they occurred:

Have you ever been hospitalized for any other reason?

Please note:
Circle current conditions and check mark former conditions

General Symptoms
- ❑ Tremors
- ❑ Headache
- ❑ Fever
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Depression
- ❑ Weight loss
- ❑ Forgetfulness
- ❑ Numbness or pain in arms, hands, joints, legs or feet
- ❑ Confusion
- ❑ Paralysis

Eyes, Ears, Nose, & Throat
- ❑ Failing vision
- ❑ Near sightedness
- ❑ Eye pain
- ❑ Eye strain
- ❑ Cross eyed
- ❑ Eye inflammation
- ❑ Glaucoma
- ❑ Deafness
- ❑ Earache
- ❑ Hearing loss
- ❑ Ear discharge
- ❑ Ear noises
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Nasal drainage
- ❑ Loss of smell
- ❑ Sinus infection
- ❑ Hay fever
- ❑ Allergies
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Difficult swallowing
- ❑ Loss of taste
- ❑ Taste changes
- ❑ Dental decay
- ❑ Gum troubles
- ❑ Tonsillitis
- ❑ Asthma
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Enlarged glands

Skin
- ❑ Skin eruptions
- ❑ Clammy skin
- ❑ Dryness
- ❑ Bruise easily
- ❑ Boils
- ❑ Rashes
- ❑ Sensitive skin
- ❑ Hives or allergies

Respiratory
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Wheezing

Cardiovascular
- ❑ Rapid heartbeat
- ❑ Slow heartbeat
- ❑ Irregular heartbeat
- ❑ Pain over heart
- ❑ Previous heart stroke
- ❑ Hardening of arteries
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Paralytic stroke
- ❑ Varicose veins

Muscles and Joints
- ❑ Stiff neck
- ❑ Pain between shoulders
- ❑ Backache
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture
- ❑ Swollen joints
- ❑ Stiff joints
- ❑ Painful joints
- ❑ Arthritis
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Sciatica

Genitourinary
- ❑ Frequent urination
- ❑ Scanty urine
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection or stones
- ❑ Bed wetting
- ❑ Inability to control urine
- ❑ Prostrate issues
- ❑ Foul smelling urine
- ❑ Discolored urine

Gastrointestinal
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Gas
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Distention of abdomen
- ❑ Diarrhea
- ❑ Black stool
- ❑ Blood in stool
- ❑ Colon trouble
- ❑ Hemorrhoids (piles)
- ❑ Intestinal worms
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis
- ❑ Weight trouble

Female
- ❑ Painful menstrual periods
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycles
- ❑ Cramps or backache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Vaginal pain
- ❑ Congested breast
- ❑ Breast pain
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Abnormal bleeding
- ❑ Reduced sexual energy
- ❑ Pregnancy
- ❑ Pregnancy complications

Male
- ❑ Painful/swollen genitals
- ❑ Reduced sexual ability/desire
- ❑ Excessive sexual desire
- ❑ Weak erection
- ❑ Premature ejaculation
- ❑ Seminal emission
- ❑ Low sperm count
- ❑ Impotence
- ❑ Frequent masturbation
- ❑ Swollen/itching scrotum
- ❑ Low sperm count
- ❑ Poor morphology
- ❑ Poor motility
- ❑ Testicular pain
- ❑ Urethra pain/discharge
- ❑ Genital odor