IRIE Natural Center for Health

GENERAL HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION:			
Name		Date	
Height	Weight	DOB	Age

WHAT IS YOUR MAJOR SYMPTOM/PROBLEM?	DATE SYMPTOM BEGAN
1.	
2.	

ACCIDENT INFORMATION:

Is your condition due to an accident? □No □ Yes Date:_____ Type of accident? □ Automobile □ Work □ Home □ Other

MEDICATIONS: (All medication including aspirin or vitamin supplements)	DOSAGE	HOW OFTEN TAKEN

PATIENT CONDITION

Have you had this problems before? □ Yes □ No

Is your condition getting progressively worse? □ Yes □ No

Is the problem: ? □ Constant □Comes and goes □ worse in am/pm

How does it feel? □ Burning □ Sharp □ Shooting □ Dull □Aching □ Stiff □ Tingling □ Throbbing □ Swelling □tearing □knifelike □ excruciating □numbness □ pins and needles □ Bone pain □ Other _____

Circle below the severity of your current pain on a scale of 0-10

(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

Circle below the *maximum severity* of pain experienced on a scale of 0-10

(No pain) **0 1 2 3 4 5 6 7 8 9 10 (severe pain)**

What makes your condition better? _____

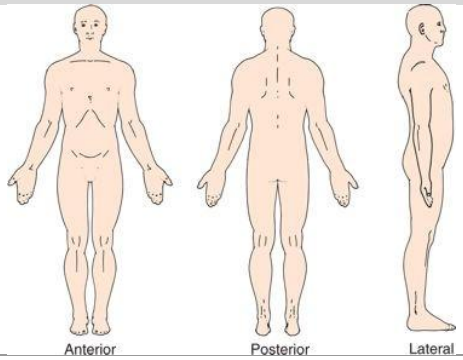
What makes your condition worse? _____

Does it interfere with your □ Work □ Sleep □Daily Routine □Recreation □ Sports □Hobbies □ Other

What activities/movements are painful to perform: □Sitting □Standing □Walking □Bending □ Lying down □ Getting up □Turning neck/ trunk □ When still or moving □ driving

What treatment or therapies have you have tried? □ Physical therapy □ Chiropractor □Acupuncture □injections □ Other Did it help? Y/N

Place mark where it hurts



PAST HEALTH HISTORY

Have you been diagnosed with □ Cancer □ High Blood Pressure □ Diabetes □ other
Any Surgeries related to current issue? □Yes □ No What year: _____
Any major accidents?□ Y □N What year: _____
Any fractures? ?□ Y □N What year: _____
Have you had any imaging □ X-rays □ MRI □ CT □ Ultra Sound □ LABs
Any Allergies to medication? □ Y □N
Are you currently taking anticoagulants such as Asprin, Warfarin or Coumadin? □ Y □N

SOCIAL HEALTH HISTORY

Do you smoke cigarettes? □ Y □N #per day _____
Do you drink alcohol? □ Y □N □ occasionally
Are you currently working? □ Y □N Occupation? _____ Do your job duties include □ desk job □ standing □ lifting □stooping□ kneeling □ twisting of body□ turning of neck □ bending neck.
Do job duties involve, lifting up to____lbs x ___per week
How many hours a night do you sleep? _____ Does your pain interfere with your sleep?□Yes □No
Do you feel anxious? □ Y □N Depressed? □ Y □N
Cannabis Experience: □New □Moderate □Experienced

ORGAN SYSTEM REVIEW- DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

General: □chills □fever □weight loss □night sweats □ night pain □am stiffness □rashes

Heent: □ Ear ringing □Headaches □ Blurry vision □ glaucoma □nasal fractures □ Tooth pain □Jaw pain

Musculosketal: □Neck injury □back pain □weakness □muscle/joint pain or stiffness □paralysis □limitation of movement □ Arthritis □Fibromyalgia □ muscle atropy □ Muscle spasms

Cardio: □ Chest pain □Murmurs □ Cardiac disorder

Lungs: □shortness of breath □Asthma □ Respiratory disorder

Abdomen: □ Chron's disease □ Hepatitis C □ Nausea □ Vomiting □ Decreased appetite □Constipation □Diarrhea □Rectal Bleeding □ bowel dysfunction □ bladder dysfunction BM's per/day___
Any pain with urination? □ Y □N

Male: □ Prostate cancer □ Testicular cancer Last PSA/DRE_____

Female: □PMS □Heavy Bleeding □pelvic pain □vaginal discharge Date of last menstrual cycle: _____

Breast: □ Cancer □ Prior surgery/biopsy Last mammogram_____

Neuro: □MS □Epilepsy □ ALS □ Alzheimer's □ fainting □dizziness □ numbness □ tingling/burning □Tremors □Stroke □ Seizures □ Headaches