

HEALTH HISTORY

Please Print Legibly

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

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

Current issue(s) for which you are seeking help: _____ Date began: _____

Top 5 health concerns: _____

What are your current health goals? _____

What types of therapies have you tried for these problem(s) or to improve your health over-all?

- Diet modification Fasting Vitamins/minerals Herbs Homeopathy
- Chiropractic Acupuncture Conventional drugs
- Other _____

Do you experience any of these general symptoms currently

- Fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
- Depression Panic attacks Nausea Fecal incontinence Bleeding
- Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
- Disinterest in eating Dizziness Diarrhea Low-grade fever Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

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

| Year | Surgery/Illness | Outcome |
|-------|-----------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Physical Injuries, Traumas - recent & past accidents, car accidents, sports injuries, falls etc:

| Year | Injury/Trauma | Outcome |
|-------|---------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Did you play football or do gymnastics or cheerleading in the past? _____

Circle your current level of stress (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today: _____

How was your health as a child? _____ Did you have a traumatic birth? _____

Medical History/Symptom Survey

Neurological

- ADD/ADHD
- Alcoholism
- Cold feet
- Cold hands
- Dental problems
- Depression
- Dizziness
- Drug addiction
- Eating disorder
- Balance Problems
- Epilepsy
- Eyes, ears, nose problems
- Blurred vision
- Light bothers eyes
- Glaucoma
- Facial pain
- Facial twitch
- Fainting
- Fatigue
- Inner tension
- Irritability
- Learning disabilities
- Loss of smell or taste
- Mental illness
- Nervousness
- Neurological problems (Parkinson's, paralysis)
- Numbness/Pins/Needles Arms
- Numbness/Pins/Needles Legs
- Ringing in ears
- Seasonal affective disorder

Vital Organs

- Allergies/hay fever
- Alzheimer's disease
- Anemia
- Arthritis
- Asthma
- Auto Immune disease
- Bed-wetting
- Blood pressure problems
- Bronchitis
- Breathing Problems
- Cancer
- Chest pain
- Cholesterol, elevated
- Chronic fatigue syndrome
- Circulatory problems

- Cold sores/herpes
- Diabetes
- Environmental sensitivities
- Fibromyalgia
- Genetic disorder
- Gout
- Heart disease
- HIV/Aids
- Infection, chronic
- Kidney or bladder disease
- Liver/gallbladder disease (stones)
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Sinus problems
- Skin problems
- Stroke
- Swollen ankles
- Swollen joints
- Thyroid trouble
- Urinary tract infection
- Varicose veins

Physical Structure

- Shooting head pain
- Pain Shoulder/arm
- Pain in neck
- Pain in mid back
- Pain in low back
- Painful joints
- Pain in legs/feet
- Pain or tension in jaw
- Carpal tunnel syndrome
- Spinal curvature
- Migraine headaches
- Muscle spasms
- Grinding in neck
- Hernia

Digestion

- Stomach trouble
- Colitis
- Constipation
- Diverticular Disease
- Digestive complaint
- Food intolerance

- Gastro-esophageal reflux disease
- Indigestion
- Inflammatory bowel disease
- Intestinal gas
- Irritable bowel syndrome
- Ulcer

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive
- Infertility
- Sexually transmitted disease

Medical (Women)

- Menstrual irregularities
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Decreased sex drive
- Sexually transmitted disease
- Menopause

Are you pregnant? Y N

Mammogram Y N

of children _____

Health Habits

- Tobacco: #/day _____
- Alcohol: # of drinks/wk. _____
- Caffeine:
Coffee: #6 oz cups/day _____
Tea: #6 oz cups/day _____
Soda w/caffeine: #cans/day _____
- Water: #glasses/day _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration/
workout _____
- 30-45 minutes duration per
workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic -
#days/wk _____
- Weight lift - #days/wk _____
- Stretch - #days/wk _____