Health History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Who referred you?_____ Primary Care Physician: _____Dr.#_____

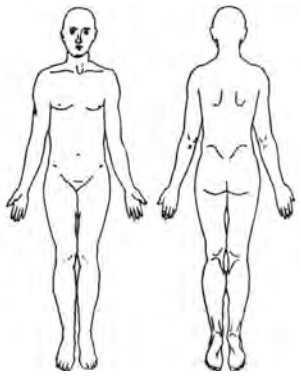
Occupation: _____ Marital Status_____ (married/single/partner/divorced/widow(er)

Age: ____ Height:____ Weight:____ Sex: ____ Number of Children____

Reason for Office Visit: _____

_____

How Long have you had problem?_____ What started the problem?_____



Please indicate on diagram where you are experiencing pain.

What types of therapy have you tried for this problem/condition? (Please circle)

Diet modification vitamins/minerals herbs homeopathy chiropractic

acupuncture conventional medicines physical therapy

How would you rate your pain today? Please circle.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Severe Pain**

Please circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

What are the major causes of your stress? (i.e.: changes in job, residence, finances, legal issues, etc.)

_____

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

_____

Drug Allergies/reactions: _____

Major hospitalizations and dates, surgeries, injuries: (please list all procedures and any complications):_____

_____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months?

_____

Office use only:

Do you experience any of these symptoms EVERYDAY?
(Please check appropriate box(es)

- ❑ Debilitating fatigue
- ❑ Depression
- ❑ Disinterest in sex
- ❑ Disinterest in eating
- ❑ Shortness of breath
- ❑ Panic attacks
- ❑ Headaches
- ❑ Dizziness
- ❑ Insomnia
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Fecal incontinence
- ❑ Urinary incontinence
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Rectal bleeding
- ❑ Discharge
- ❑ Itching/rash
- ❑ Diarrhea

Family History
(Grandparents, Parents & Siblings)

- ❑ Arthritis
- ❑ Alzheimer's disease
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Heart disease
- ❑ Mental illness
- ❑ Obesity
- ❑ Stroke
- ❑ Cancer

Other____

Please turn over and complete the back page.

Your Medical History (Please check appropriate box(es)

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose Veins
- ❑ Other (please list below)

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreases sex drive
- ❑ Infertility
- ❑ Other:

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Other:

- ❑ Form of birth control:

- ❑ # of children:_____
- ❑ # of pregnancies: ___
- ❑ C-section
- ❑ Surgical menopause
- ❑ Menopause
- ❑ Date of last menstrual cycle:

Any recent changes in normal menstrual flow? (e.g. heavier, large clots, scanty, etc.)

Health Habits

Tobacco:
Cigars or Cigarettes#/day:

Alcohol:
drinks/ week:

Caffeine:
Coffee: #6oz. 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 per workout
- ❑ 30-45 minuted duration per workout
- ❑ Less than 30 minutes

Nutrition and Diet

- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ Total calorie restriction

Specific food restriction:

- ❑ Dairy
- ❑ Wheat
- ❑ Eggs
- ❑ Soy
- ❑ Corn
- ❑ All gluten
- ❑ Other:

Eating Habits

- ❑ Skip breakfast
- ❑ Three meals/day
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/Mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, Source:

- ❑ Vitamin D
- ❑ Magnesium
- ❑ Zinc
- ❑ Other Minerals
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino Acids
- ❑ CoQ10
- ❑ Antioxidants
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Protein Shakes
- ❑ Superfoods (e.g. bee pollen, phytonutrients)
- ❑ Liquid meals
- ❑ Glucosamine Sulfate
- ❑ Chondroitin Sulfate
- ❑ SAMe
- ❑ Tumeric (curcumin)

Office Notes:

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