Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention, which is not included on this form, please note it in the Comments section or speak to us about it. Thank you.

Name:______________________________Home Phone:__________Cell Phone:__________

Address:____

City:________________________State:________Zip:________ Job Title:____________

Email address:________________________________Email is used for appt reminders and newsletters only. Initial:______

Date of Birth: ______________Height:____________Weight:____________Marital Status:________

Emergency Contact Name:____________________Emergency Contact Phone:______________

Referred By:________________________Family Physician:__________________________

What is the main problem (s) you would like help with today? (List in order of importance)

1.____

2.____

3.____

When did this problem begin? (please be specific)

1.____________________2.____________________3.____________________

What was the cause of this problem: ____

____

What makes it better: (hot, cold, massage, etc.)______________________________

____

What makes it worse: (activity, weather, AM, PM) ____________________________

____

What kind of treatment have you tried?______________________________________

____

What treatment has been helpful?____

Is your current condition getting: ______better ______worse ______comes & goes ______same

What is the level of pain or intensity on a scale of 1-10 (10 worst, 0 none):__________

What % of day do you experience relief if any?__________

Current Medication and Supplements: ______________________________________

____

____

Significant Trauma Incidents or Surgery (auto accidents, falls, hitting head, broken bones, etc.) *Please include dates*:

____

____

Do you have a regular exercise program? If so, please describe: ____________________

____

Please describe your average daily diet: Morning: ____________________

Afternoon: ____________________ Evening: ____________________

How many cigarettes do you smoke a day? __________ How much coffee/tea or cola do you drink per day? __________

How much alcohol do you drink per week? __________ How much nicotine do you chew per week? __________

Please describe any use of drugs for non-medical purposes: ____________________

____

Please check any symptoms you have had in the last three months

GENERAL

- ❑ Chills
- ❑ Fevers
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot)
- ❑ No thirst
- ❑ Fatigue
- ❑ Sudden Energy drop
- ❑ Edema
- ❑ Poor sleeping
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Weight gain
- ❑ Weight loss

SKIN AND HAIR

- ❑ Rashes
- ❑ Itching
- ❑ Ulcerations
- ❑ Eczema
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff

FACE, EARS, EYES, NOSE & THROAT

- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
- ❑ Glasses
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Dry eyes
- ❑ Blind spot(s)
- ❑ Spots in front of eyes
- ❑ Eye pain
- ❑ Cataracts
- ❑ Excessive tearing
- ❑ Discharge from eyes
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Earache
- ❑ Ear discharge
- ❑ Grinding teeth
- ❑ Jaw clicks
- ❑ Jaw tension
- ❑ Teeth problems
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Sores on lips or tongue
- ❑ Hoarseness
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Facial pain

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Chest pain/discomfort
- ❑ Cold hands or feet
- ❑ Swelling in hands or feet
- ❑ Blood clots
- ❑ Phlebitis
- ❑ Fainting
- ❑ Difficulty breathing

RESPIRATORY

- ❑ Cough
- ❑ Asthma/Wheezing
- ❑ Pain with deep breath
- ❑ Asthma
- ❑ Difficulty breathing when lying down
- ❑ Production of phlegm
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Bronchitis

GASTRO-INTESTINAL

- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Belching
- ❑ Ulcers
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Laxative use
- ❑ Gas
- ❑ Rectal pain
- ❑ Hemorrhoids

GENITO-URINARY

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Blood in urine
- ❑ Incomplete urination
- ❑ Dribbling
- ❑ Decrease in flow
- ❑ Kidney stones

- ☐ Impotency
- ☐ Sores on genitals
- ☐ Pain with intercourse
- ☐ Change in sexual drive
- ☐ Waking at night to urinate
- ☐ How often__________
- ☐ Peculiar color
- ☐ Particular odor

PREGNANCY & GYNECOLOGY

Number of pregnancies________

Number of births_____________

Number or premature births_____________

Number of miscarriages_________

Number of abortions__________

Number of ectopic pregnancies__________

Age at first menses_____________

How many days between menses____________

Duration of menses___________

Date of last menses_________

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ PMS
- ☐ Clots
- ☐ Menopause
- ☐ Breast lumps
- ☐ Nipple discharge

Last PAP_________

- ☐ Birth control

Type______________

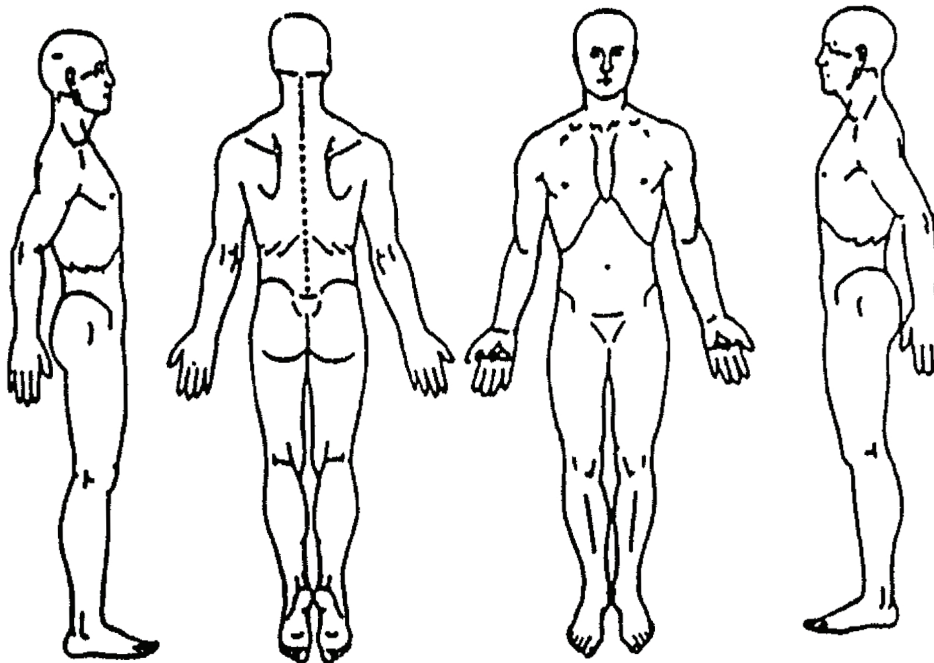
How long___________

MUSCULO-SKELETAL

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Mid-back pain
- ☐ Spinal pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle weakness

NEURO-PSYCHOLOGICAL

- ☐ Seizures
- ☐ Numbness
- ☐ Weakness
- ☐ Sleep problems/disorder
- ☐ Bad dreams
- ☐ Concussion
- ☐ Bad temper
- ☐ Mood swings
- ☐ S.A.D.
- ☐ Violent potential
- ☐ Vertigo
- ☐ Loss of balance
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse
- ☐ Ever treated for emotional problems
- ☐ Ever attempted or considered suicide



Please mark the body diagrams with the following letters to indicate what you have been experiencing:

P=Pain, T=Tighntess, N=Numbness/Tingling, W=Weakness.

Next to the letter write a number 0 (No Pain) to 10 (Extreme Pain) conveying the intensity of your experience.