NAME: ____________________________ DATE of BIRTH: __________________________

Health History

Please circle: C= Current condition/circumstance P= Past condition/circumstance

General:
Fatigue C P
Night sweats C P

Skin:
Rashes C P
Eczema, hives C P
Other: _______ C P

Head:
Headaches C P
Migraines C P
Hair loss C P
Head injury C P
Dizziness C P

Eyes:
Change in vision C P
Double vision C P
Eye pain C P
Tearing/Dryness C P
Glasses/Contacts C P

Ears:
Hard of hearing C P
Ringing C P
Ear ache C P

Nose/Sinuses:
Frequent colds C P
Stuffiness C P
Sinus infections C P
Hay fever C P
Nose bleeds C P

Mouth & throat:
Sore Throat C P
Swollen Tongue C P
Difficulty swallowing C P

Neck:
Lumps C P
Pain or stiffness C P

Respiratory:
Asthma C P
Emphysema C P
Frequent cough C P
Bronchitis C P
Shortness of Breath C P
Wheezing C P
Pain on breathing C P
Pneumonia C P

Cardiovascular:
Heart failure C P
Heart attack C P
Chest pain/angina C P
High blood pressure C P
High cholesterol C P
Fluttering in chest C P
Heart murmur C P
Ankle Swelling C P

Gastrointestinal:
Frequent indigestion C P
Nausea C P
Vomiting C P
Abdominal pain C P
Liver disease C P
Heartburn C P
Ulcers C P
Hemorrhoids C P
Constipation C P
Diarrhea C P
Frequency Bowel movements?
______________ ______
Is this a change? Y N

Urinary:
Pain on urination C P
Increased frequency C P
Dribble urine C P
Frequent infections C P
Kidney stones C P

Musculoskeletal:
Joint pain/stiffness C P
Arthritis C P
Broken bones C P
Osteoporosis C P
Muscle spasms C P
Muscle weakness C P
Loss of coordination C P
Sprains/Strains C P

Peripheral vascular:
Blood clots C P
Anemia C P
Bleeding/bruising C P
Varicose veins C P
Cold hands/feet C P
Raynauds disease C P

Cancer C P
Type:__________________
Stage: _________________

Neurologic:
Head injury C P
When? ______________
Stroke C P
Seizures C P
Fainting C P
Paralysis C P
Numbness/Tingling C P
Memory loss C P
Loss taste or smell C P
Loss of balance C P

Endocrine:
Hyperthyroid C P
Hypothyroid C P
Heat Intolerance C P
Cold Intolerance C P
Diabetes C P
Excessive Thirst C P

Emotional:
Depression/sadness C P
Anxiety C P
Mood swings C P
Anorexia C P
Bulimia C P

Male reproductive:
Hernias C P
Prostate disease C P
Sexually active C P
Sexual difficulties C P
Difficulty conceiving C P
STD's C P

Female reproductive:
Length of cycles _________
Regular cycles C P
Skipped cycle(s) C P
Breakthrough bleeding C P
Menopausal symptoms C P
Sexually active C P
Pain with intercourse C P
Birth control C P
What type? _____________
Difficulty conceiving C P
STD's C P
Sexual difficulties C P
Vaginal infections C P
No. of pregnancies _______
No. of live births ________
No. of miscarriages _______
No. of abortions _________

NAME: ____________________________ DATE of BIRTH: _________________________

HABITS:	Y	N	EXERCISE:	Y	N
Tobacco: How much/how often? ___________ For how long have you smoked?_____________			Exercise Routinely? What Forms?_____________________ How often? ______________________		
Alcohol: How much? _______________ How often? ______________			Do you enjoy it?		
Use Recreational Drugs?			WORK:		
Do you drink caffeinated products?			What Type?______________________________		
Do you drink 4-8 glasses of water daily?			Do you enjoy it?		
SLEEP:			Do you work unusual hours?		
Do you fall asleep easily?			LIVING SITUATION:		
Do you get between 6-8 hours of sleep each night?			With whom do you live? ____________________		
Awaken rested?			Do you enjoy where you live?		

PSYCHOLOGICAL/EMOTIONAL/SPIRITUAL LIFE:

What are your current stressors? ____

How do you manage stress? ____

History of depression/anxiety? ____

Hobbies:____

Is a spiritual life important to you? If yes, please explain:____

How would you describe your support system?____

Family Health History: *Immediate Family Only*

✓	ILLNESS	Who?	✓	ILLNESS	Who?
	Cancer (type)			Asthma	
	Diabetes			Anemia	
	Heart Disease			Kidney Disease	
	High Blood Pressure			Glaucoma	
	High Cholesterol			Osteoporosis	
	Stroke			Tuberculosis	
	Epilepsy			Rheumatoid Arthritis	
	Mental Illness			Thyroid Disease	
	Autoimmune dis.				

NAME: ______________________________ DATE of BIRTH: ________________________

CURRENT HEALTH CONCERNS

Reason(s) for Today's Visit? ____

How did symptoms start?

TIMING: When did symptoms start?

Circle: **Are the symptoms constant or intermittent? Does the intensity of the symptoms fluctuate? Y / N**

When during the day is your pain the worst? ____________________ **When is it best?** ______________________

QUALITY: Quality of pain: *Circle: Burning, Stabbing, Aching, Throbbing, Dull, Sharp, Penetrating, Tiring, Tender, Nagging, Tingling, Miserable, Shooting, Stabbing, Intermittent, Gnawing, Exhausting, Numb, Unbearable*

Severity of Pain NOW: *Circle* (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Highest level over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

Lowest level over the PAST 2 WEEKS: 0 1 2 3 4 5 6 7 8 9 10

What aggravates your pain? ____

What relieves your pain?____

Medications that you've tried: e.g. – Opioids, Antidepressants, Muscle relaxants, Anti-inflammatories, etc.

NAME:	Did it help?	NAME:	Did it help?

What other **treatments** / **therapies** have you tried? e.g. – injections, massage, chiropractic, etc.

TYPE:	Did it help?	TYPE:	Did it help?

What **diagnostic imaging** have you had? e.g. - XRAY, MRI, CT SCAN or OTHER

STUDY	DATE	BODY PART	RESULT

NAME: ______________________________ DATE of BIRTH: ________________________

YOUR MEDICAL HISTORY:

Height__________ **Weight**______________

✓	ILLNESS	When Diagnosed?	STABLE?	✓	ILLNESS	When Diagnosed?	STABLE?
	Cancer (type)				Asthma		
	Diabetes				Anemia		
	Heart Disease				Kidney Disease		
	High Blood Pressure				Glaucoma		
	High Cholesterol				Osteoporosis		
	Stroke				Tuberculosis		
	Epilepsy				Rheumatoid Arthritis		
	Mental Illness				Thyroid Disease		

CURRENT PRESCRIPTION DRUGS for ANY reason: *Drug & Dose*

Drug Name	Dose	How Often?

SUPPLEMENTS:

Allergies to Medications: ____

Allergies to Food, Environmental or Other Substances: ____

Trauma History:

Motor Vehicle Accidents? Y N When? _______________, ______________, ________________

Concussions or Loss of Consciousness? Y N Age(s)? ___________, __________, ____________

Broken Bones? Y N Age(s): ___________, __________, ____________

Significant Falls? Y N Age(s): ___________, __________, ____________

Any other traumatic events that you believe impacted your health? ________________________________

HOSPITALIZATIONS OR SURGERIES: ***Please list reason/type of surgery and date.***

REASON/TYPE	DATE