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HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential.

Name *(First, M.I, Last)*:	**Today's date:**	**Date of Birth:**
Address*(City, State, Zip)*:		
Mobile Phone:	**Email:**	
Home Phone:	**How do you prefer to be contacted:** ☐ Phone ☐ Text ☐ Email	
☐ **Male** ☐ **Female**	**Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

How were you referred to us?:	**Have you seen other holistic practitioners?**
Current primary care doctor:	**Date of last physical exam:**
Date of last laboratory tests:	**Any abnormal tests?:**

What has prompted you to schedule a consultation?

Please list below any symptoms you are having or any health concerns:

Symptom or Health concerns	Date started	Diagnosis given	Treatments received

What do you feel is the cause of your symptoms?

Social History

What is your occupation?			Are you currently employed? ☐ Yes	☐ No
Do you like your job?	Past occupations:			
How would you rate your stress Level?	☐ Mild	☐ Manageable	☐ Very stressed	☐ Excessive stress
Are you exposed to chemicals at work?				
Do you have any children?	If yes, how many?		Do they live with you?	
Do you have any pets?	Do you have any allergies to your pets or other animals?			
Do you use perfume, hair dye, fabric softener or synthetic household cleaners? (please circle)				
Do you use chemicals on the lawn or garden?				
Do you spray pesticides or other chemicals in the house for spiders, ants or other pests?				

Dental History

Do you have any amalgam (silver) fillings	If yes, how many?	
Have you had any amalgam fillings in the past and had them removed?		When?
Do you have any root canals?	If yes, how many?	How old?
Have you had your wisdom teeth removed?		
Do you have any gold crowns or fillings?		
Do you currently have any tooth pain or sensitivity to hot or cold?		

Name: _____

Please state your health goals: _____

_____

Please list any allergies to medications, foods or environmental factors: _____

_____

Personal Health History

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates (if known)				
	☐ Tetanus	☐ Rotavirus	☐ DTap	
	☐ Hepatistis A	☐ Hepititis B	☐ Polio	
	☐ Influenza	☐ Hib	☐ Meingococcal	

Were there any reactions to any of the vaccines? ☐ Yes ☐ No

List all Surgeries:

Year	Reason	Hospital

Other hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List ALL medications, including herbs, supplements, topical creams, etc.

Medication/Supplement	Prescribed Dosage (e.g.mg amount)	Frequency Taken

Health Habits

Are you on any special diet? (please describe)

How often do you consume: sugar coffee soft drinks fried foods potato chips fast food

Do you smoke cigarettes? For how many years? Smoke cigars or pipe? For how many years?

Do you drink alcohol? If yes, what type and how often?

Do you currently use recreational or street drugs? Have you used in the past? What type?

Have you ever been diagnosed with a sexually transmitted disease such as herpes, gonorrhea, HIV or syphilis?

Religion or spiritual belief: Do you have a regular or daily spiritual practice such as prayer or meditation?

Do you have any past or current history of verbal, physical or sexual abuse?

Name: _____

Family Health History

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Siblings	M F			M F	
	M F			M F	
	M F		**Grandmother** Maternal		
	M F		**Grandfather** Maternal		
	M F		**Grandmother** Paternal		
	M F		**Grandfather** Paternal		

WOMEN ONLY

1. Age at onset of menstruation: _____
2. Date of last menstruation: _____ Any difficulty conceiving? _____
3. How many days in a regular cycle? _____ Any change in your libido (sex drive)? _____
4. Heavy periods, irregularity, spotting, pain or discharge (circle any or all)? ☐ **Yes** ☐ **No**
5. Number of pregnancies: _____ Number of live births: _____ Are you pregnant or breastfeeding? _____
6. Have you ever had kidney stones? ☐ **Yes** ☐ **No**
7. Have you had a D&C, hysterectomy, or Cesarean? ☐ **Yes** ☐ **No**
8. Any urinary tract, bladder, or kidney infections within the last year? ☐ **Yes** ☐ **No**
9. Any pain, frequency, urgency or blood in urine? ☐ **Yes** ☐ **No**
10. Any problems with control of urination? ☐ **Yes** ☐ **No**
11. Any hot flashes or sweating at night? ☐ **Yes** ☐ **No**
12. Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ **Yes** ☐ **No**
13. Any recent breast tenderness, lumps, or nipple discharge? ☐ **Yes** ☐ **No**
14. Date of last pap and rectal exam? _____ Any uterine fibroids? _____ Any vaginal sores? _____

MEN ONLY

1. Do you urinate at night? ☐ **Yes** ☐ **No**
2. If yes, # of times: _____ Have you ever had kidney stones or infection? _____
3. Do you feel pain or burning with urination? ☐ **Yes** ☐ **No**
4. Any blood in your urine? ☐ **Yes** ☐ **No**
5. Do you feel burning or have discharge from your penis? ☐ **Yes** ☐ **No**
6. Has the force of your urination decreased? ☐ **Yes** ☐ **No**
7. Have you had any kidney, bladder or prostate infections within the last 12 months? ☐ **Yes** ☐ **No**
8. Do you have any problem emptying your bladder completely? ☐ **Yes** ☐ **No**
9. Any difficulty with erection or ejaculation? ☐ **Yes** ☐ **No**
10. Any testicle pain or swelling? ☐ **Yes** ☐ **No**
11. Date of last prostate and rectal exam? _____ Any change in libido (sex drive)? ☐ **Yes** ☐ **No**

Name: _____

OTHER PROBLEMS

Check the condition below if it is a current issue, or if it has been an issue in the past **(P=Past, C=Current)**

General

__Anemia
__Fatigue
__Fever
__Weight loss _____lbs
__Sweat easily
__Night sweats
__Chills
__Poor appetite
__Localized weakness
__Bleed or bruise easily
__Peculiar tastes or smells
__Strong thirst
__Cravings
__Poor sleep habits
__Tremors
__Poor balance
__Frequent cold/flu
__Weight gain _____lbs
__Alcoholism
__Drug addiction
__Other

Skin and Hair

__Rashes
__Itching
__Dandruff
__Dry skin
__Change in hair/skin texture
__Psoriasis
__Acne
__Eczema
__Jaundice
__Nail problems
__New moles
__Hair loss
__Hives
__Open sores
__Other: _____

Head, Eyes, Ears, Nose and Throat

__Dizziness/Vertigo
__Poor vision
__Cataracts
__Teeth grinding
__Sinus problems
__Nasal congestion
__Discharge from eyes
__Ringing in ears
__Concussions
__Eye strain
__Night blindness
__Blurry vision
__Poor hearing
__Nose bleeds
__Hoarseness
__Mouth or lip sores
__Migraines
__Eye pain
__Colorblindness
__Earaches
__Spots in vision
__Recurrent sore throats
__Facial pain
Headaches: Where_____

Cardiovascular

__High blood pressure
__Low blood pressure
__Palpitayons
__Pacemaker
__Irregular heartbeat
__Chest pain/discomfort
__Bleeding disorder
__Swelling of hands or feet
__Fainting
__Other: _____
__Blood clots
__Cold hands/feet
__Difficulty breathing
__Varicose veins

Respiratory

__Cough
__Bronchitis
__Difficulty breathing lying down
__Coughing blood
__Pneumonia
__Asthma
__Pain w/ deep breath
__Phlegm
__Other: _____

Gastrointestinal

__Nausea
__Vomiting
__Bad breath
__Ulcer
__Indigestion
__Abdominal pain or cramps
__Constipation
__Flatulence
__Blood in stools
__Rectal pain
__Chronic laxative use
__Colitis
__Diarrhea
__Belching
__Black stools
__Hemorrhoids
__Acid reflux
__Other: _____

Musculoskeletal

__Neck pain
__Back pain
__Hand/wrist pain
__Muscle weakness
__Metal implants
__Muscle pain
__Elbow pain
__Shoulder pain
__Numbness
__Other: _____
__Knee pain
__Foot/ankle pain
__Hip pain
__Tingling

Neuropsychological

__Seizures
__Sleep problems
__Concussion
__Dizziness
__Easily stressed
__Lack of coordination
__Depression
__Difficulty concentrating
__Loss of balance
__Poor memory
__Anxiety
__Other: _____

The above information is accurate and complete to the best of my knowledge:

Signature: _____ Date: _____