

Health Questionnaire

Please complete this questionnaire carefully. All information will be held in absolute confidence.

Name	Date	_____	___
Address	Social Security Number	_____	_
_____	Date of Birth	_____	Age _____
Phone - Cell	Phone - Work	_____	___
Employer _____	Height _____	Weight _____	_____
Occupation	Marital Status	_____	___
Email address _____	Referred by	_____	___
Emergency contact	Emergency phone	_____	_

Main Problem(s) _____

Does this problem interfere with daily activities? Please explain. _____

Have you been given a diagnosis for this problem? _____

Personal History: (check all that apply, note history & treatment)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Family Medical History (Please identify the family member's relation to you)

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Surgeries: (Please include date) _____

Significant Trauma: (Describe accidents, falls...with dates, treatment, & results) _____

Medicines taken within the last two months (including vitamins, drugs, herbs...) _____

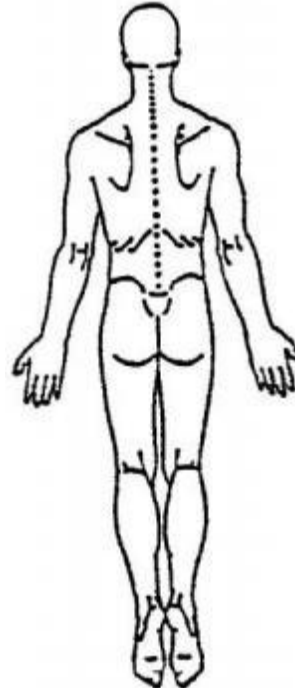
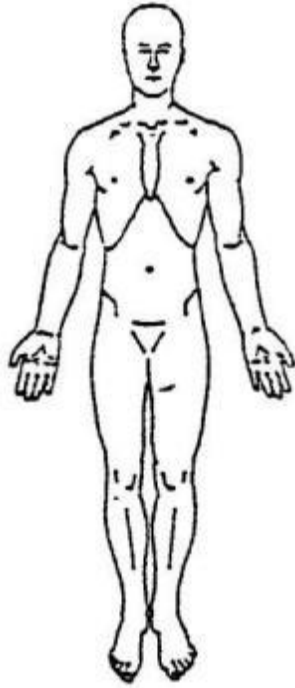
Allergies: (Causes, symptoms, discomforts) _____

How many cigarettes do you smoke a day? _____

How much coffee, tea, or cola do you drink a day? _____

How much alcohol do you drink during a typical week? _____

Indicate Painful or Distressed Areas. Explain as fully as possible.



Please explain if you have had any of the following within the last 3 months

GENERAL:

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Changes in Appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Poor Sleep / Trouble Sleeping |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Sweating Easily | <input type="checkbox"/> Localized Weakness |
| <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sudden Energy Drop |
| <input type="checkbox"/> Cravings (circle all that apply)
sugar salt sour spicy | <input type="checkbox"/> Bleed or Bruise easily | Time of Day _____ |
| | <input type="checkbox"/> Tremors | |

SKIN & HAIR

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itches | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Change in hair or skin texture | Other _____ | |

CARDIOVASCULAR

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Swelling in Feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in Breathing |

Other Heart or Circulatory Problems _____

RESPIRATORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with Deep Breaths |
| <input type="checkbox"/> Difficulty Breathing When Lying Down | <input type="checkbox"/> Production of Phlegm - Color? _____ | |

Other Lung Problems _____

HEAD, EYES, EARS, NOSE & THROAT

- Recurrent Sore Throats Ear Aches Poor Vision
- Sores on Lips or Tongue Poor Hearing Cataracts
- Sinus Problems Teeth Problems Ringing in Ears
- Nose Bleeds Grinding Teeth Blurry Vision
- Facial Pain Clicking Jaw Eye Strain
- Concussion(s) Night Blindness Eye Pain
- Dizziness Glasses Spots in Front of Eyes
- Migraines Color Blindness

Headaches - where & when _____

Other head or neck problems _____

GASTROINTESTINAL

- Nausea Vomiting Diarrhea
- Constipation Gas Belching
- Black Stools Blood in Stools Indigestion
- Bad Breath Rectal Pain Hemorrhoids
- Abdominal Pain or Cramps Other Stomach or Intestinal Problems _____

GENITO- URINARY

- Pain on Urination Frequent Urination Blood in urine
 - Urgent Urination Unable to Hold Urine Sores on Genitals
 - Decrease in Urine Flow Kidney Stones Impotence
 - Waking at night to Void - How Often _____ Color of Urine _____
- Other Problems with Genitalia or Urinary System _____

REPRODUCTIVE & GYNECOLOGIC

- Pregnancies _____ Date of Last menses _____ Irregular Periods
- Births _____ Length of Menses _____ No Periods
- Miscarriages _____ Days Between Menses _____ Breast Lumps or Pain
- Abortions _____ Flow Heavy Light Chronic Yeast Infections
- Last PAP _____ Clots Dark Red Menopause - Age _____

Birth Control Type & Length of Use _____

Pain with Cycle Beginning Ending Ovulation PMS Psyche Body

Vaginal Discharge/Leukorrhea - please describe _____

MUSCULOSKELETAL

- Neck pain Muscle Pain Knee Pain
 - Back Pain Muscle Weakness Foot/Ankle Pain
 - Hand/Wrist Pain Shoulder Pain Hip Pain
- Other Joint or Bone Problems _____

NEUROPSYCHOLOGICAL

- Seizures Dizziness Loss of Balance
- Areas of Numbness Lack of Coordination Poor memory
- Concussion Depression Anxiety
- Bad Temper Low Tolerance for Stress

Have you been treated for emotional problems? _____ Have you considered or attempted suicide? _____