Your Health History

Name ____ Date ______________

Please print legibly

Occupation ___________________ Age _____ Height _______ Sex _____ Number of Children _____

Relationship Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Current issue(s) for which you are seeking help:

____ Date issue began: __________

____ Date issue began: __________

Top 5 health concerns:

1. ______________________ 2. ______________________ 3. ______________________
4. ______________________ 5. ______________________

What are your current health goals? ____

What types of therapies have you tried for these problem(s) or to improve your health over-all? ☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs ☐ Other ____

Do you experience any of these general symptoms currently? ☐ Fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation ☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding ☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low-grade fever ☐ Itching/rash

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

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

Major Hospitalizations, Surgeries,Please list all procedures, complications (if any) and dates:

Year Surgery/Illness Outcome

____ ____ ____________ ______________________________________

____ ____ ____________ ______________________________________

Physical Injuries, Traumas - recent & past accidents, car accidents, sports injuries, falls etc:

Year Injury/Trauma Outcome

____ ____ ____________ ______________________________________

____ ____ ____________ ______________________________________

Did you play football or do gymnastics or cheerleading in the past? ____________________________

Circle your current general level of stress (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right   Your weight today: ______________
How was your health as a child? __________________________________   Did you have a traumatic birth? ☐ Yes ☐ No

Medical History/Symptom Survey

Neurological

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Cold feet
- ☐ Cold hands
- ☐ Dental problems
- ☐ Depression
- ☐ Dizziness
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Balance Problems
- ☐ Epilepsy
- ☐ Eyes, ears, nose problems
- ☐ Blurred vision
- ☐ Light bothers eyes
- ☐ Glaucoma
- ☐ Facial pain
- ☐ Facial twitch
- ☐ Fainting
- ☐ Fatigue
- ☐ Inner tension
- ☐ Irritability
- ☐ Learning disabilities
- ☐ Loss of smell or taste
- ☐ Mental illness
- ☐ Nervousness
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Numbness/Pins/Needles Arms
- ☐ Numbness/Pins/Needles Legs
- ☐ Ringing in ears
- ☐ Seasonal affective disorder

Vital Organs

- ☐ Allergies/hay fever
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune disease
- ☐ Bed-wetting
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chest pain
- ☐ Cholesterol, elevated
- ☐ Chronic fatigue syndrome
- ☐ Circulatory problems
- ☐ Cold sores/herpes
- ☐ Diabetes
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Genetic disorder
- ☐ Gout
- ☐ Heart disease
- ☐ HIV/Aids
- ☐ Infection, chronic
- ☐ Kidney or bladder disease
- ☐ Liver/gallbladder disease (stones)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Sinus problems
- ☐ Skin problems
- ☐ Stroke
- ☐ Swollen ankles
- ☐ Swollen joints
- ☐ Thyroid trouble
- ☐ Urinary tract infection
- ☐ Varicose veins

Physical Structure

- ☐ Shooting head pain
- ☐ Pain Shoulder/arm
- ☐ Pain in neck
- ☐ Pain in mid back
- ☐ Pain in low back
- ☐ Painful joints
- ☐ Pain in legs/feet
- ☐ Pain or tension in jaw
- ☐ Carpal tunnel syndrome
- ☐ Spinal curvature
- ☐ Migraine headaches
- ☐ Muscle spasms
- ☐ Grinding in neck
- ☐ Hernia

Digestion

- ☐ Stomach trouble
- ☐ Colitis
- ☐ Constipation
- ☐ Diverticular Disease
- ☐ Digestive complaint
- ☐ Food intolerance
- ☐ Gastro-esophageal reflux disease
- ☐ Indigestion
- ☐ Inflammatory bowel disease
- ☐ Intestinal gas
- ☐ Irritable bowel syndrome
- ☐ Ulcer

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease
- ☐ Menopause

Are you pregnant? Y N
Mammogram Y N
# of children ___________

Health Habits

- ☐ Tobacco: #/day _________
- ☐ Alcohol: # of drinks/wk. ______
- ☐ Caffeine:

Coffee: #6 oz 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 duration/ workout ______________
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk - #days/wk _________
- ☐ Run, jog, other aerobic – #days/wk ______________
- ☐ Weight lift - #days/wk ______
- ☐ Stretch - #days/wk ________

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