

HEALTH HISTORY

Name _____ Date of birth _____ Date _____
 Address _____ City _____ State _____ Zip Code _____
 Phone _____ E-mail _____
 Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

Date of last physical exam _____ Practitioner name and phone number _____

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

 Outcome _____

What types of therapy have you tried for this problem(s):
 diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
 other _____

List current health problems for which you are being treated: _____

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

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

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (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 _____
 Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

 Corrective lenses Dentures Hearing aid Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: see hear taste smell feel hot/cold sensations
 move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)
 Strong like for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty
 Strong dislike for any one of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty
 Do you: Prefer warmth (i.e., food, drinks, weather, etc.) Prefer cold (i.e., food, drinks, weather, etc.) No preference
 Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the worst or your symptoms are aggravated:	Time of day you feel the most energy or the least symptoms are aggravated
<input type="checkbox"/> 7 a.m. - 9 a.m. <input type="checkbox"/> 9 a.m. - 11 a.m. <input type="checkbox"/> 11 a.m. - 1 p.m.	<input type="checkbox"/> 7 a.m. - 9 a.m. <input type="checkbox"/> 9 a.m. - 11 a.m. <input type="checkbox"/> 11 a.m. - 1 p.m.
<input type="checkbox"/> 1 p.m. - 3 p.m. <input type="checkbox"/> 3 p.m. - 5 p.m. <input type="checkbox"/> 5 p.m. - 7 p.m.	<input type="checkbox"/> 1 p.m. - 3 p.m. <input type="checkbox"/> 3 p.m. - 5 p.m. <input type="checkbox"/> 5 p.m. - 7 p.m.
<input type="checkbox"/> 7 p.m. - 9 p.m. <input type="checkbox"/> 9 p.m. - 11 p.m. <input type="checkbox"/> 11 p.m. - 1 a.m.	<input type="checkbox"/> 7 p.m. - 9 p.m. <input type="checkbox"/> 9 p.m. - 11 p.m. <input type="checkbox"/> 11 p.m. - 1 a.m.
<input type="checkbox"/> 1 a.m. - 3 a.m. <input type="checkbox"/> 3 a.m. - 5 a.m. <input type="checkbox"/> 5 a.m. - 7 a.m.	<input type="checkbox"/> 1 a.m. - 3 a.m. <input type="checkbox"/> 3 a.m. - 5 a.m. <input type="checkbox"/> 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

<input type="checkbox"/> Debilitating fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chronic pain/inflammation
<input type="checkbox"/> Depression	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Disinterest in sex	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Discharge
<input type="checkbox"/> Disinterest in eating	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Itching/rash

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Surgical menopause
- Menopause
- Date - last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)