Welcome! This **Health History Questionnaire** is a very important diagnostic procedure for assessing your health. Please take the time to thoroughly complete this form. Your personal information will be kept confidential according to federal HIPPA regulations.

1. PATIENT INFORMATION **How did you find us?** □ Family/Friend □ Facebook □ Google □ Doctor □ Other _____

a. Name	First		Middle		Last		
Address	Street		City			State	Zip
b. Phone: Home		**c.** Date of Birth	/ /	**d.** Occupation			
Work		Age		**e.** Health Ins.			
Email		Weight		Plan Type			
Emergency #		Height		Member ID#			
Fax		Sex	M / F	*If you are not the primary Ins. Holder:*			
Referred by		Marital Status	M S D W	Primary Name			
f. Physician's Name		Phone		Date of Birth			
Address				Relationship to Primary			

2. CASE HISTORY – PURPOSE OF VISIT

Chief Complaint		Onset Date
List symptoms, location, duration, severity		

List any conditions that make your symptoms better or worse:

Better	Worse

Complaint is the result of ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other _____

Other Concurrent Therapies

Have you seen other doctors about this condition? YES / NO If yes, when?

If yes, list doctor's name and treatment results:

Please list current prescriptions, over-the-counter medications, supplements, herbs, and vitamins (attach additional pages if necessary):

Names of Medications Taken	Purpose/Use	Any Side Effects?

3. FOR FEMALES

Are you pregnant? YES / NO IF YES, HOW LONG?_____

4. FOR MINORS

List both parents names and addresses	

5. PATIENT'S PAST MEDICAL HISTORY (check all that apply and include dates in spaces provided)

☐ Allergies	_____	☐ High blood pressure	_____	☐ Seizures	_____	☐ Thyroid disease	_____
☐ Pneumonia	_____	☐ Heart disease	_____	☐ Hepatitis	_____	☐ Birth trauma	_____
☐ Surgeries	_____	☐ Injuries/accidents	_____	☐ AIDS	_____	☐ Frequent colds	_____
☐ Trauma	_____	☐ Childhood illness	_____	☐ TB	_____	☐ Rheumatic fever	_____
☐ Cancer	_____	☐ Tumors/growths	_____	☐ Diabetes	_____	☐ Venereal disease	_____
☐ Anemia	_____	☐ Hospitalizations	_____	☐ Herpes	_____	☐ Food/med allergies	_____

Additional comments / Other:

6. LIFESTYLE

Do you drink coffee or soda?	YES / NO	Do you smoke?	YES / NO	Do you use recreational drugs?	YES / NO	List factors that decrease stress	
How many drinks per day?		How many packs per day?		How many times per week?			
Do you eat fast food?	YES / NO	Do you drink alcohol?	YES / NO	Do you feel stressed?	YES / NO	List factors that increase stress	
How many times per week?		How many drinks per week?		Stress level (1 min – 10 max)			

---- TURN OVER PLEASE →

7. FAMILY MEDICAL HISTORY

☐ Alcoholism ☐ Asthma ☐ Diabetes ☐ High blood pressure ☐ Seizures ☐ Tobacco use
☐ Allergies ☐ Cancer ☐ Heart disease ☐ Recreational drugs ☐ Stroke ☐ Tumors/Growths

Additional Family Medical History Comments:

8. EXERCISE

Describe any exercise you may practice	

9. DIET

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	
Cravings	

10. GENERAL (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep ☐ Fevers ☐ Chills
☐ Change in appetite ☐ Fatigue ☐ Tremors ☐ Insomnia ☐ Night sweats ☐ Sweats easily
☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen ☐ High energy ☐ Localized weakness
☐ Poor coordination ☐ Sudden energy drop at _____(time) ☐ Strong thirst (cold / hot drinks) _____ ☐ Vertigo
☐ Peculiar tastes / smells _____ ☐ Bleed or bruise easily (where) _____ ☐ Cravings _____

Additional comments / Other:_____

11. Head, Eyes, Ears, Nose, Throat (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Concussions ☐ Eye pain / strain ☐ Blurry vision ☐ Ear ringing / tinnitus ☐ Mucus ☐ TMJ / jaw problems
☐ Facial tension / pain ☐ Night blindness ☐ Cataracts ☐ Sinus problems ☐ Dry throat ☐ Sore(s) on lip
☐ Dizziness ☐ Spots in vision/floaters ☐ Poor vision ☐ Nose bleeds ☐ Allergies ☐ Sore(s) in mouth
☐ Migraines ☐ Color blindness ☐ Glaucoma ☐ Gum problems ☐ Dry mouth ☐ Sore(s) on tongue
☐ Swollen glands ☐ Glasses / contacts ☐ Hearing loss ☐ Teeth grinding ☐ Hay fever ☐ Poor sense of smell
☐ Lack focus/concentration ☐ Dryness ☐ Tearing ☐ Earaches ☐ Copious saliva ☐ Teeth problems ☐ Poor sense of taste
☐ Headaches ☐ Itchy eyes ☐ Other head or neck problems ☐ Post nasal drip ☐ Recurrent sore throats _____ *per month* ☐ Thyroid problems
(*where & when*) _____

Additional comments / Other:_____

12. Respiratory (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Chest pain /pressure ☐ Difficulty breathing ☐ Night sweats ☐ Persistent coughing ☐ Asthma ☐ Spontaneous sweating
☐ Shortness of breath ☐ Restricted breathing ☐ Pleurisy ☐ Phlegm / Mucous ☐ Emphysema ☐ Spitting / coughing blood

Additional comments / Other:_____

13. Gastroitestinal (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Abdominal pain ☐ Bad breath ☐ Black stools ☐ Blood / pus in stools ☐ Colitis ☐ Recurrent belching
☐ Ulcers ☐ Diarrhea ☐ Gas ☐ Hemorrhoids ☐ Indigestion ☐ IBS ☐ IBD
☐ Loose stools after meals ☐ Nausea ☐ Heartburn ☐ Rectal pain ☐ Liver disease ☐ Crohn's disease
☐ Appetite change ☐ Food allergies ☐ Vomiting ☐ Weight gain ☐ Hepatitis B or C ☐ Gall Bladder disease
☐ Tired after eating ☐ Food intolerances ☐ Bloating ☐ Weight Loss ☐ Celiac ☐ Recurrent Hiccups
☐ Constipation ☐ Gluten intolerance ☐ Large appetite ☐ Small appetite ☐ Skip meals ☐ Lactose intolerance

☐ Laxative use:_____/week; type_____. Additional comments / Other:_____

14. Musculoskeletal (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Ankle pain ☐ Wrist pain ☐ Shin pain ☐ Upper back pain ☐ Broken bone(s) ☐ Decreased range of motion
☐ Knee pain ☐ Elbow pain ☐ Neck pain ☐ Lower back pain ☐ Joint pain ☐ Sensitivity to weather
☐ Leg pain ☐ Arm pain ☐ Hand pain ☐ Muscle pain ☐ Osteoporosis ☐ Facial pain
☐ Hip pain ☐ Shoulder pain ☐ Foot pain ☐ Traumatic injury ☐ Arthritis ☐ Rib pain

Additional comments / Other:_____

15. Neuropsychological (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Speech problems ☐ Numbness / tingling ☐ Bad temper ☐ Hearing voices ☐ Concussion ☐ Difficulty staying asleep
☐ Obsessive thoughts ☐ Seizures / Epilepsy ☐ Paralysis ☐ Panic attacks ☐ Busy minded ☐ Loss of consciousness
☐ Compulsive behavior ☐ Depressed mood ☐ Loss of balance ☐ Vertigo / dizziness ☐ Insomnia ☐ Difficulty falling asleep
☐ Dreams / nightmares ☐ Paranoid thoughts ☐ Anxiety ☐ Shakes / tremors ☐ Shingles ☐ Poor memory
☐ Treated for emotional problems_____ ☐ Easily stressed ☐ Considered/attempted suicide

Please list any psychological problems you have been treated for, if any?_____

☐ Emotionally even ☐ Lacking motivation ☐ Nervous feelings ☐ Feeling stuck ☐ Irritable ☐ Emotionally-more down
☐ Frustrated ☐ Busy-minded ☐ Overthinking ☐ Anxious ☐ indecisive ☐ Emotionally-more up

16. Skin and Hair (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Change in skin color ☐ Boils / Carbuncles ☐ Acne ☐ Ulcerations ☐ Dandruff ☐ Change in hair texture
☐ Easily bruised ☐ Eczema ☐ Hair loss ☐ Hives ☐ Itching ☐ Sores that don't heal
☐ Pimples ☐ Rashes ☐ Swelling

Additional comments / Other: _____

17. Cardiovascular (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Irregular heartbeat ☐ Chest pain / tightness ☐ Blood clots ☐ Chest fullness ☐ Stroke ☐ Palpitations / fluttering
☐ High blood pressure ☐ Cold hands / feet ☐ Bleeding easily ☐ Low blood pressure ☐ Heart murmurs ☐ Swelling of feet / ankles
☐ Rheumatic fever ☐ Varicose veins ☐ Heart disease ☐ Angina ☐ Fainting ☐ Phlebitis

Additional comments / Other: _____

18. Genitourinary (please check ☑ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Change in urine flow ☐ Sexual dysfunction ☐ Blood in urine ☐ Frequent urination ☐ Frequent UTI ☐ Decreased sexual desire
☐ Unable to hold urine ☐ Restricted urination ☐ Impotency ☐ Pain on urination ☐ Kidney stones ☐ Pain during intercourse
☐ Waking up to urinate ☐ Sore(s) on genitals ☐ Genital pain ☐ Urgent urination ☐ Discharge ☐ Burning upon urination

Additional comments / Other: _____

Are you sexually active? YES / NO
How many times do you urinate per 24 hours? _____
Additional comments / Other: _____

Describe the qualities of your urine: ☐ Clear ☐ Yellow- ☐ Light or ☐ Dark ☐ Large amount ☐ Small amount ☐ Cloudy ☐ Strong smelling

19. OB/GYN (for females only - please check all that apply)

Pregnancies YES / NO	Miscarriages YES / NO	# of Births	Birth control YES / NO	Premature births YES / NO
#	#	# of Abortions	Type	#
			Duration	

☐ Amenorrhea ☐ Hot flashes ☐ Vaginal sores ☐ Changes to body / psyche prior to menstruation _____
☐ Breast tenderness ☐ Vaginal discharge ☐ Breast lumps ☐ PMS

Describe your last menstrual			1st Day of Last menses		Duration of menses	
	☐ Change in flow	☐ Clots	Color		Age at 1st menses	
	☐ Heavy flow	☐ Irregular flow	Cycle length (in days)		Age at menopause	
	☐ Light flow	☐ Painful menstruation				

Additional comments / Other: _____

20. CLASSICAL (check all that apply to describe your preferences)

General mood / emotionally	☐ Angry	☐ Excited	☐ Worried	☐ Pensive	☐ Sad	☐ Scared ☐ Frightened
Favorite season(s)	☐ Spring	☐ Summer	☐ Late/Indian summer		☐ Autumn	☐ Winter
Least Favorite season(s)	☐ Spring	☐ Summer	☐ Late/Indian summer		☐ Autumn	☐ Winter
Favorite climate	☐ Windy	☐ Hot	☐ Humid	☐ Damp	☐ Dry	☐ Cold
Least favorite climate	☐ Windy	☐ Hot	☐ Humid	☐ Damp	☐ Dry	☐ Cold
Taste(s) you enjoy	☐ Sour	☐ Bitter	☐ Sweet		☐ Acrid/Pungent/Spicy	☐ Salty
Taste(s) you dislike	☐ Sour	☐ Bitter	☐ Sweet		☐ Acrid/Pungent/Spicy	☐ Salty
Favorite time of day	☐ Before sunrise		☐ Morning		☐ Afternoon	☐ Evening
Problematic time of day	☐ Before sunrise		☐ Morning		☐ Afternoon	☐ Evening
Favorite color(s)	☐ Green	☐ Red	☐ Yellow		☐ White	☐ Blue ☐ Black ☐ Purple

Final comments / Other: _____

I understand the information I provided on this questionnaire is essential to determine my health and treatment needs. I have read and understood each question and certify it to be true and correct to the best of my knowledge and belief and hereby grant authorization for treatment, in accordance with state statutes, for the care and management of this complaint.

PATIENT'S SIGNATURE _____ DATE _____
(PARENT'S SIGNATURE IF PATIENT IS A MINOR)