HEALTH HISTORY
Questionnaire & Registration

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By Appointment Only
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PATIENT INFORMATION

Date _____

Name _____

Address _____

City/State/Zip _____

Age _____ Date of birth _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number _____

How did you hear about us? _____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

E-mail _____

Another person we may contact if needed:

Name _____

Relationship _____

Home phone _____

Work phone _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1) _____

2) _____

3) _____

How is your sleep? _____

How is your digestion? _____

List medications or food supplements you are taking.

List serious illnesses, accidents or surgeries.

Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Cancer ☐ Heart disease ☐ Kidney disease

Check symptoms you have or have had in the last year:

- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry
- ☐ Excessive anger
- ☐ Excessive fear
- ☐ Fatigue/tiredness
- ☐ Headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

Check conditions you have or have had in the past:

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Diabetes

When was your last complete medical exam?

_____

HEALTH HISTORY continued

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- ☐ Tremors / Cramps
- ☐ Swollen joints

Pain, weakness, numbness in:

- ☐ Arms or Hips
- ☐ Back Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ☐ Asthma / wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching / rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

GENITO/URINARY

- ☐ Blood / pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles

GASTROINTESTINAL

- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

FOR WOMEN ONLY

- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant? _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____