HEALTH QUESTIONNAIRE

Name Date / / Age Height Weight Sex

Family Medical History

❑ Allergies
_____
_____
❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism
❑ Cancer
_____
_____
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Seizures
❑ Stroke
❑ Mental Illness

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past, or feel are a significant part of your medical history)

❑ AIDS/HIV
❑ Alcoholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Arthritis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Caesarean
❑ Chicken Pox
❑ Disease
❑ Eating Disorder
❑ Emotional Trauma
❑ Emphysema
❑ Epilepsy
❑ Fracture
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Hernia
❑ Herniated Disc
❑ High Blood Pressure
❑ Kidney Disease
❑ Knocked Unconscious
❑ Measles
❑ Mental Illness
❑ Migraines
❑ Miscarriage
❑ Mono
❑ Multiple Sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Stroke
❑ Surgery (list)
_____
_____
❑ Thyroid Disorders
❑ Tuberculosis
❑ Typhoid Fever
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough
❑ Major Trauma (car, fall, etc.—list)
_____
_____
❑ Other (specify)
_____
_____
_____

Your Diet

Appetite ❑ Low ❑ High
❑ Coffee
❑ Soft Drinks
❑ Artificial Sweetener
❑ Sugar
❑ Salty Food
❑ Thirst for water
glasses/day:_____

Average Daily Menu

Morning Snack Noon Snack Evening Snack

Pharmaceuticals taken in last 2 months_____
Vitamins/supplements taken in last 2 months_____

Your Lifestyle

❑ Alcohol
❑ Tobacco
Mattress/futon?
How much sleep/night?_____
❑ Marijuana
❑ Drugs
Spiritual Practice_____
How much sleep do you like to get?_____
❑ Stress
❑ Occupational Hazards
Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____
Fun/Hobby_____

General Symptoms

❑ Poor appetite
❑ Heavy appetite
❑ Strongly like cold drinks
❑ Strongly like hot drinks
❑ Recent weight loss/gain
❑ Poor sleep
❑ Heavy sleep
❑ Dream-disturbed sleep
❑ Fatigue
❑ Lack of strength
❑ Bodily heaviness
❑ Cold hands or feet
❑ Poor circulation
❑ Shortness of breath
❑ Fever
❑ Chills
❑ Night sweats
❑ Sweat easily
❑ Muscle cramps
❑ Vertigo or dizziness
❑ Bleed or bruise easily
❑ Peculiar taste (describe)
_____
_____
_____

Head, Eyes, Ears, Nose, Throat

❑ Glasses
❑ Eye strain
❑ Eye pain
❑ Red eyes
❑ Itchy eyes
❑ Spots in eyes
❑ Poor vision
❑ Blurred vision
❑ Night blindness
❑ Glaucoma
❑ Cataracts
❑ Teeth problems
❑ Grinding teeth
❑ TMJ
❑ Facial pain
❑ Gum problems
❑ Sores on lips or tongue
❑ Dry mouth
❑ Excessive saliva
❑ Sinus problems
❑ Excessive phlegm
❑ Color of phlegm
_____
_____
❑ Recurrent sore throat
❑ Swollen glands
❑ Lumps in throat
❑ Enlarged thyroid
❑ Nose bleeds
❑ Ringing in ears
❑ Poor hearing
❑ Earaches
❑ Headaches
❑ Migraines
❑ Concussions
Other head or neck problems
_____
_____
_____

Respiratory

❑ Difficulty breathing when lying down
❑ Shortness of breath
❑ Tight chest
❑ Asthma/wheezing
❑ Cough
Wet or dry?_____
Thick or thin?_____
Color of phlegm
_____
❑ Coughing blood
❑ Pneumonia

Cardiovascular

❑ High blood pressure
❑ Blood clots
❑ Low blood pressure
❑ Fainting
❑ Chest pain
❑ Difficulty breathing
❑ Tachycardia
❑ Heart palpitations
❑ Phlebitis
❑ Irregular heartbeat

Musculoskeletal

❑ Neck/shoulder pain	❑ Upper back pain	❑ Joint pain	❑ Limited range of motion	❑ Other (describe)
❑ Muscle pain	❑ Low back pain	❑ Rib pain	❑ Limited use	_____

Skin and Hair

❑ Rashes	❑ Eczema	❑ Dandruff	❑ Fungal infections	❑ Other (describe)
❑ Hives	❑ Psoriasis	❑ Itching	❑ Hair loss	_____
❑ Ulcerations	❑ Acne	❑ Change in hair/skin texture		_____

Neuropsychological

❑ Seizures	❑ Poor memory	❑ Irritability	❑ Considered/attempted Suicide	❑ Other (specify)
❑ Numbness	❑ Depression	❑ Easily stressed		_____
❑ Tics	❑ Anxiety	❑ Abuse survivor	❑ Seeing a therapist	_____

Genito-urinary

❑ Pain on urination	❑ Blood in urine	❑ Venereal disease	❑ Increased libido	❑ Impotence
❑ Frequent urination	❑ Unable to hold urine	❑ Bedwetting	❑ Decreased libido	❑ Premature ejaculation
❑ Urgent urination	❑ Incomplete urination	❑ Wake to urinate	❑ Kidney stone	❑ Nocturnal emission

Gynecology

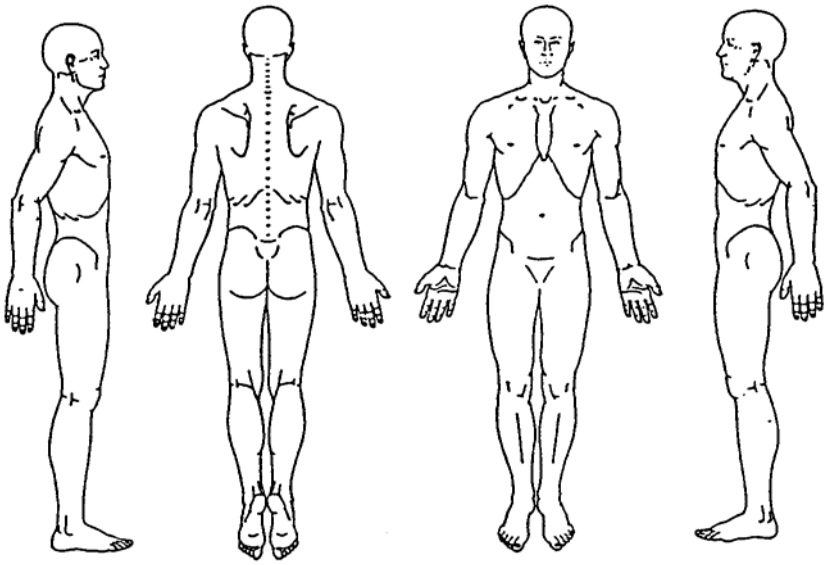
❑ Age menses began _____	❑ Duration of flow	❑ Vaginal discharge (color)_____	❑ Breast lumps	Date of last PAP _____
Length of cycle (day 1 to day 1)_____	❑ Irregular periods	❑ Vaginal sores	# Pregnancies_____	
	❑ Painful periods	❑ Vaginal odor	# Live births_____	
	❑ PMS	❑ Clots	# Premature births_____	Date last period began
			Age at Menopause_____	_____

Other

Please use the following key to accurately mark the areas in which you feel the described sensations. Use the appropriate symbols and include all affected areas.

Dull ⸗ ⸗ ⸗ Stabbing/Cutting / / / / Burning ≈ ≈ ≈ Other o o o

Numb = = = = Tingling : : : : : : Cramping S S S



Please place one mark on the line below to indicate your present pain level

No pain ----------Worst pain ever

Using the scale of 0-100, with 0=no pain, and 100=worst possible pain, please write the number indicating your present pain level in the box at the right: ☐

Date of last: (approx)

Physical exam_____

Blood test_____

Chest X-Ray_____

Spine X-Ray_____

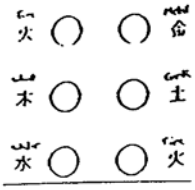
Dental X-Ray_____

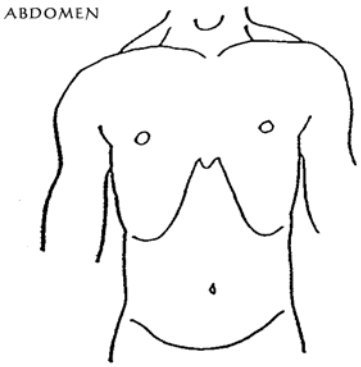
Urine X-Ray_____

CT Scan_____

MRI_____

Bone Density_____





After reading and filling out the Health Questionnaire, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Signature _____ Date _____