



Health History Questionnaire

Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. **All of your answers will be confidential.** If you have questions, please ask. Thank-you.

Name _____ Age _____ M F Today's Date _____

Blood Type if Known _____ Birthdate _____

Home Address _____

Tel (home) _____ Tel (work) _____ Occupation _____

Spouse's Name _____ Children (name/age) _____

If the above is a child: Mother's Name _____ Father's Name _____

Other Healthcare Providers (Name/Telephone)

Medical _____ Doctor _____

Chiropractor _____

Other _____

Other _____

How you found out about the clinic/Referred by: _____

Emergency Contact: _____

Main Health Concern(s):

When did your problem(s) begin?

Have you been given a diagnosis?

What treatments/therapies have you tried?

Past Medical History (please check all that apply and list approximate date):

- | | | |
|----------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Other: _____ | | |

Surgeries:

Significant Trauma:

Birth History (prolonged labour, forceps delivery, etc):

Allergies (chemical, environmental, food):

Family Medical History:

- Allergies
- Arthritis
- Asthma
- Other

- Cancer
- Diabetes
- Heart Disease

- High Blood Pressure
- Seizures
- Stroke

Occupational Stress (include chemical, physical & psychological factors):

Weekly Exercise Routine:

Current Medicines (include prescription, over-the-counter, vitamins, herbs, homeopathics & dosages):

Diet:

Are you on a restricted diet?

Please describe your average daily diet:

Breakfast	Lunch	Dinner

How many cigarettes do you smoke per day?

How much coffee, tea or cola do you drink per day?

How much alcohol do you drink per week?

Please describe any use of drugs for non-medical purposes:

Please check all symptoms that apply (within the last 3 months):

General

- | | | |
|---------------------------------------------|---------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Peculiar tastes or smells |

Skin & Hair

- | | | |
|---------------------------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulceration | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in skin or hair texture | | <input type="checkbox"/> Other: - |
-

Head, Eyes, Ears, Nose & Throat

- | | | |
|--------------------------------------|-------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Earaches | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Other: - |
-

Cardiovascular

- | | | |
|----------------------------------------------|---------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Other: - | |
-

Respiratory

- | | | |
|-----------------------------------------|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Production of phlegm |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pneumonia | What color? _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Other: - |
-
- Difficulty breathing when lying down

Gastrointestinal

- | | | |
|--------------------------------------|---------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Gas | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Other: - |
-

Genitourinary

- | | | |
|------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Particular color or odor to urine |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Difficulty starting or stopping urination | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Wake to urinate: how often? _____ | | |
-

Pregnancy & Gynecology

- | | | |
|----------------------------------|-------------------------------------------------------|--------------------------------------------|
| Age at first menses _____ | <input type="checkbox"/> Regular cycles | <input type="checkbox"/> Clots |
| Duration of menses (days) _____ | <input type="checkbox"/> Unusually heavy/light menses | <input type="checkbox"/> Vaginal discharge |
| Days between cycles _____ | <input type="checkbox"/> Painful menses | <input type="checkbox"/> Vaginal sores |
| Last PAP (date & results): _____ | | |
-

- | | | |
|----------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Perform self breast exams | <input type="checkbox"/> Last mammogram (date & results): _____ | |
-

- | | | |
|------------------------------------------------------|-------------------------------------------------|------------------------------------------------|
| Number of pregnancies _____ | <input type="checkbox"/> Premature births _____ | <input type="checkbox"/> Abortions _____ |
| Number of births _____ | <input type="checkbox"/> Miscarriages _____ | <input type="checkbox"/> Difficulty conceiving |
| <input type="checkbox"/> Post-menopausal (age) _____ | | |

Musculoskeletal

- | | | |
|--------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hip pain |
|--------------------------------------|------------------------------------|-----------------------------------|

- Joint pain
- Muscle weakness

- Neck pain
- Shoulder pain
- Hand/wrist pain

- Knee pain
- Foot/ankle pain
- Other:

Please describe the nature of any pain you are experiencing (eg: dull, sharp, shooting etc): _____

Neuropsychological

- Seizures
- Areas of numbness
- Concussion
- Dizziness

- Lack of coordination
- Loss of balance
- Poor memory
- Depression

- Anxiety
- Easily susceptible to stress
- Quick temper/irritable
- Other:

Details on past treatment for emotional problems:

Have you ever considered or attempted suicide?



Intake Form

1. What are your goals for your health?
2. What timeline do you think it will take to achieve this goal?
3. What other methods have you tried in the past to get to your healthy range?
4. What steps are you currently taking to promote good health?

Food Intake?

Water?

Exercise?

Stress Management?

Supplements?

5. Have you been diagnosed with any health conditions? If so, what?
6. Are you currently taking any medications?
7. Are you currently taking any vitamin supplements?
8. Is there anything we should know about your health?
9. Do you have any food allergies?