Health History Questionnaire

Case Number: ____________

This is a confidential record of your history which will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so as outlined in the privacy policy.

This is a fillable form pdf. Please fill in the shaded areas, save the file, and return via email.

Date ____________________

Name (Last) ______________________________ First ______________________________

Street ____

City ______________________________ State ______________ Zip ______________

Email Address ____

Day Phone (______) _______-___________ Evening Phone (______) _______-___________

Fax (______) _______-___________

Date of Birth ______/______/_______ Height ___________ Age ________ Sex ☐ M ☐ F

Current Weight ________________ Weight 1 Year Ago (if known) ________________

Occupation ____ Marital Status __________

Emergency Contact ______________________________ Phone (______) _______-___________

Family Physician ______________________________ Phone (______) _______-___________

How did you hear about us? ____

____

Primary concerns and goals

1. ____

____

____

____

2. ____

____

____

____

3. ____

____

____

____

Health History

Has a physician given a diagnosis for the above concerns? ______________________________

What diagnostic tests have you had done?

When did these issues begin? What you have tried for the conditions? Have the conditions changed?

If you are currently working with other health care professionals, list practitioner name and conditions treated.

Practitioners Name ______________________________

Condition ______________________________

Practitioners Name ______________________________

Condition ______________________________

Practitioners Name ______________________________

Condition ______________________________

List all allergies or sensitivities (i.e.: gluten, wheat, nuts, soy, eggs, etc.) ______________________________

Significant traumas, hospitalizations and any surgeries (note date and reason)

Medications and Supplements

List **all** medications, over the counter supplements and any herbs you are **currently** using.
Please note the dosage and time of day taking:

Name of Medication / Supplement / Herbs	Dose	Time(s) of Day

List any significant medications or supplements you have taken **in the last 10 years**, why you took it,
and your reaction to the medication (if any):

Name of Medication / Supplement / Herbs	Reason Taken	Reaction (if any)

Family Medical History
Please complete this section concerning family members with significant health issues

	Age (if deceased, age and cause of death)	Health
Father		
Mother		
Brothers/Sisters		

Systems Review

Before each item below please list severity of issue.
Range 0 – 10 (0 = not an issue, 10 = severe issue). Note location if specific.

Skin & Hair

____ Skin eruptions (rashes, etc.) _______________
____ Itching
____ Whole body crawling sensation
____ ☐ Eczema ☐ Psoriasis
____ Hives
____ Dandruff
____ Poorly healing sores
____ ☐ Acne ☐ Boils ☐ Cysts
____ Moles
____ Dry skin
____ Oily skin
____ Cracks or fissures
____ Bruise easily
____ ☐ Skin tags ☐ Warts
____ Athletes foot
____ Other skin infections, color or skin texture changes

Head, Eyes, Ears, Nose & Throat

____ Headaches how often________________
____ Migraine how often________________
____ Dizziness
____ Facial pain
____ Swollen glands
____ Earaches or ear infections
____ Tinnitus (ringing in ears)
____ ☐ Eye pain ☐ Tearing ☐ Dryness
____ ☐ Itchy ears ☐ Itchy eyes
____ Poor hearing
____ Poor vision or blurred vision, day/night
____ Spots in front of eyes
____ ☐ Cataracts ☐ Glaucoma
____ Cold sores or canker sores
____ Cracks around mouth or chapped lips
____ Sinus congestion
____ Frequent sinus infections
____ Sinus headaches
____ Nose bleeds
____ Frequent colds or sore throat
____ Post nasal drip
____ Hay fever
____ ☐ Teeth grinding ☐ Bleeding gums
____ Clicking jaw

Endocrine

____ Hypothyroid
____ Hypoglycemia
____ Hyperthyroid
____ Diabetes

Cardiovascular

Blood pressure __________/__________
____ Irregular heart beat
____ Murmur or Mitral Valve Prolapse
____ Cold hands, feet or body
____ Tingling in hands or feet
____ Varicose or spider veins
____ Chest pain or tightness
____ Palpitations
____ Racing or pounding heart
____ Dizzy when standing quickly
____ Fainting
____ Swelling in ankles or hands

Respiratory

☐ Never Smoked ☐ Presently Smoke ☐ Smoked in the Past How many years?_____ Daily Amount______

_____ Difficulty breathing ☐ with exertion ☐ without exertion

_____ Difficulty breathing when lying down

_____ Cough ☐ Dry ☐ Wet ☐ Blood

_____ Bronchitis

_____ Pneumonia

_____ Colds always settle in lungs

_____ Production of phlegm ☐ No ☐ Yes Color: ☐ Clear/White ☐ Yellow/Green ☐ Blood

_____ Pain with breathing ☐ Inhale ☐ Exhale

_____ Rapid or shallow breather

_____ Asthma

_____ Past exposure to environmental pollutants

Gastrointestinal

_____ Food cravings ________________________

_____ Bloating after eating

_____ Burping, belching

_____ Fatigue after eating

_____ Nausea ☐ AM ☐ PM

_____ Vomiting

_____ Indigestion

_____ Abdominal pain ☐ Upper ☐ Lower ☐ Mid

_____ Poor appetite

_____ Bad breath

_____ Heartburn

_____ Acid or sour taste in mouth

_____ Stomach upset easily

Do you use antacids? ☐ Yes ☐ No

_____ Difficulty swallowing

_____ Gas

_____ Discomfort under rib cage ☐ left side ☐ right

_____ Difficulty ☐ losing weight ☐ gaining weight

_____ Stomach pain ☐ before eating ☐ after eating

_____ History of ulcers or current ulcer

_____ Hemorrhoids or rectal pain

_____ History of diarrhea

_____ History of constipation

_____ Rapid elimination after meal

_____ # bowel movements per day

☐ Loose ☐ Normal ☐ Mucus ☐ Blood

☐ Hard ☐ Small ☐ Narrow or Thin

Color: ☐ black ☐ brown ☐ yellow ☐ tan

Urinary

_____ Urinary frequency Small amounts?______

_____ Painful urination

_____ Incontinence

_____ Kidney or Bladder infections

_____ Dribbling after urination

_____ Up at night to urinate # of times _______

_____ Infrequent urination large amounts

_____ Kidney stones: # of times _______ ☐ current

_____ Urine has strong odor

_____ Urine color: ☐ light ☐ dark ☐ blood ☐ cloudy

_____ Irregular flow

_____ Decreased flow

Musculoskeletal

____ Aching muscles

____ Muscle pain or spasms

____ AM stiffness that last for more than 1 hour after waking

____ As you use muscle the stiffness gets worse

____ Stiffness better with movement

____ Reduced range of motion – where ______________________________

____ Back pain – Location: ☐ Low ☐ Mid ☐ Upper

____ Joint pain – location(s) ______________________________

____ Broken bones – location(s) ______________________________

____ Arthritis – location(s) ______________________________

____ Neck pain

____ Use chiropractor __________ times per month

____ Massage/Other Bodywork __________ times per month

____ Sciatica

____ Scoliosis

____ Weak or Tired Legs

Sleep Pattern

____ Difficulty falling asleep

____ Mind doesn't turn off

____ Interrupted sleep (at what time[s]?) ______________________________

____ Still tired in AM ☐ fatigue ☐ foggy

____ Dreams ☐ bad ☐ vivid

____ Sleep Aids? What and how often ______________________________

____ Bedtime ______ Wake up time _____

Emotional

____ Stress level

____ Irritable

____ Frustration

____ Anger

____ Difficulty concentrating

____ Poor memory

____ Loss of balance

____ Anxiety

____ Spacey/foggy feeling

____ Highly emotional

____ Depressed

____ Cry easily

____ Fearful

____ Overactive mind/excessive thinking

____ Panic attacks

Immune System

____ Hayfever
____ Animal Dander, Mites, etc.
____ Bronchial Infections
____ Mononucleosis
____ HIV/AIDS
____ Fibromyalgia
____ Chronic Fatigue Syndrome
____ Interstitial Cystitis
____ Scleroderma
____ Molds, Mildew, Fungus Sensitivities/Allergy
____ Food Intolerances
____ Frequent Colds/Flu
____ Cancer, Where? ______________________________
____ Epstein Barr Syndrome
____ Cytomegalovirus
____ Lupus
____ Rheumatoid Arthritis
____ Crohn's
____ Hepatitis
____ Lyme's

Exercise

Do you exercise? How often and length of time?

____

____

____

General

____ Fatigue
____ Facial twitches
____ Increase or decrease in weight recently
____ Excessive thirst
____ More than 3 colds per year
____ Intolerant to ☐ heat ☐ cold
____ Sensitive to humidity (makes you uncomfortable)

Habits

Do you drink alcohol? ☐ No ☐ Yes If yes, what is the frequency and amount? _________________________

Do you have a history of alcohol or drug abuse? ____

How often do you drink any of the following?

Coffee ______________________________ Tea ________________________________ ☐ Caffeinated

Soda ______________________________ ☐ Diet ☐ Caffeine

Additional Notes

(To be filled out by the herbalist):

Pulse:

Tongue:

Other: