HEALTH HISTORY QUESTIONNAIRE

DIRECTIONS: *Please complete this form to the best of your ability and bring it to your initial consultation. This provides us with valuable information to address your health concerns most effectively. This information will be kept strictly confidential.*

Client Name: _____ Age: _____ Gender: ❒ M ❒ F Date: _____
Date of Birth: _____ Birth time: _____ Birth place: _____ Referred by: _____
Address: _____ Email: _____
Phone: _____ Emergency Contact/ Contact Info:_____

PRIMARY/ SECONDARY CONCERNS

Please list your major health concerns (& any accompanying symptoms) in order of importance to you. If you have received a diagnosis for your complaints, please list and provide date of diagnosis. Specify any relevant information such as cause, location, nature, frequency, duration, and intensity. Describe factors that aggravate these symptoms, and how they affect or impair daily activities. Next to each of these concerns please classify your condition as:

A- severe **B**- getting worse **C-** staying the same **D-** mild

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICATION HISTORY

Please list any medications/ supplements/ vitamins/ herbs, etc. that you are currently taking. (or attach typed list)

Dosage *Time period taken* *For what condition/symptom*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

DRUG HISTORY

List any allergies, drug sensitivities, or reactions:_____

Checkmark current use or *circle* past use of substances. Write quantity per day or week next to each substance:

❒ Alcohol ❒ Tobacco ❒ Cigarettes
❒ Marijuana ❒ Psychedelics ❒ Other

Health History Questionnaire

Family History

Checkmark which blood relatives are still living, or if deceased please give cause of death.

Mother	❒ Living ❒ Deceased	_____
Father	❒ Living ❒ Deceased	_____
Siblings # _____	❒ Living ❒ Deceased	_____
Maternal grandparents	❒ Living ❒ Deceased	_____
Paternal grandparents	❒ Living ❒ Deceased	_____

Circle family hx of:

Addiction	Heart disease
Alcoholism	Hypertension
Allergies	Kidney disease
Arthritis	Mental disorder
Asthma	Scoliosis
Cancer	Stroke
Diabetes	Ulcers
Epilepsy	Glaucoma
Other:	

Personal History

Please list and explain answers to any of the following questions.

Please list childhood illnesses: _____

Please list **Childhood Trauma** and when it occurred (age & year): _____

❒ Verbal Abuse ❒ Physical Abuse ❒ Sexual Abuse ❒ PTSD ❒ Other type of abuse:

Please list significant **Adult Trauma** and when it occurred (age & year):_____

❒ Verbal Abuse ❒ Physical Abuse ❒ Sexual Abuse ❒ PTSD ❒ Other type of abuse:

❒ Did you receive counseling to process trauma? Y N

Please list serious **Illness/ Hospitalizations**: _____

_____

Please list **Surgeries, Injuries, or Accidents**: (Please give age and outcome.) _____

_____

_____

Mental & Emotional Health

Checkmark all that apply

❒ Anxious	❒ ADHD- attentive deficit	❒ Easily Overwhelmed
❒ Prone to Panic Attacks	❒ Poor Memory	❒ Anger/ Rage
❒ Fearful	❒ Poor Concentration	❒ Impatient
❒ Ungrounded	❒ Indecisive	❒ Easily Frustrated
❒ Insecure	❒ Suppress/ Deny Emotions	❒ Irritable/ Agitated
❒ Lonely	❒ Trouble Letting Go	❒ Critical/ Judgmental
❒ Mood Swings	❒ Grief/ Sadness	❒ Violent/ Aggressive Tendencies
❒ Hysterical/ Excitable	❒ Attached/ Possessive	❒ Competitive
❒ Impulsive, Erratic	❒ Depression	❒ Jealous/ Envious
❒ Confused, Uncertain	❒ Stubborn, Resistant to Change	❒ Over-Reactive
❒ Emotionally Sensitive	❒ Apathetic/ Unresponsive	❒ Currently In Psychotherapy ❒ In The Past
❒ Foggy Thinking	❒ Lethargic, Lazy	❒ Bipolar Disorder
❒ Active, Restless Mind	❒ Suicide Attempt How long ago?	❒ Perfectionist
❒ Creative & Inspired	❒ Compassionate/ Forgiving	❒ Determined/ Focused
❒ Sharp Memory & Focus	❒ Cheerful/ Grateful	❒ Goal Oriented
❒ Emotionally Balanced	❒ Mental Illness, please explain diagnosis and treatment:	

HEALTH HISTORY QUESTIONNAIRE

LIFESTYLE HISTORY

Please rate your overall level of health. (Very Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Relationship Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated For how long? _____

Is your relationship stable? Y N Are you happy in your relationship? Y N Do you feel fulfilled? Y N

Are you comfortable /happy with your home environment? Y N Why? _____

Stress levels: please rate from (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Do you handle stress well? Y N Do you feel easily overwhelmed? Y N Use stress management techniques? Y N

Do you have a stressful occupation? Y N Occupation: _____ For how long? _____

Do you feel fulfilled in your job? Y N Why? _____

Are you comfortable /happy with your financial situation? Y N Why? _____

What you do to relax: (hobbies?) _____

Do you meditate? Y N How frequent? _____ Describe practice: _____

Do you have a spiritual practice? Y N Do you incorporate prayer? Y N Describe practice: _____

How many hours of TV/ day? _____ hrs TV/week _____ hrs type of programs: _____

How many hours do you spend in front of computer/ day? _____ hrs type of work: _____

Energy levels: please rate from (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What time of day is your energy highest? _____ Lowest? _____

Have you ever been diagnosed with chronic fatigue? Y N When? _____ For How Long? _____

Exercise: Do you do exercise daily? Y N If yes, for how long? _____ If not, how frequent? _____

Do you do yoga? Y N How frequent? _____ What type of yoga: _____

Describe yoga practice: _____

Do you use a personal trainer? Y N How frequently? _____

Circle types of activity: Cardiovascular Aerobic Weight Training Strength training Competitive sports

Walking Hiking Jogging Cycling Rowing Swimming Pilates Skiing Tennis Other _____

Describe frequency: _____

What is the most important health change you would like to occur?

Please add any additional information about yourself that you would like to share.

INTEGRATIVE MODALITIES EXPERIENCED:

❒ Acupuncture ❒ Ayurveda ❒ Chiropractic ❒ Craniosacral ❒ Homeopathy ❒ Hypnotherapy ❒ Naturopathy ❒ Reflexology

❒ Massage Type: _____ ❒ Other: _____

How long ago? _____ For what condition? _____ Was it successful? Y N

Health History Questionnaire

Dietary History & Nutrition

Of Meals per day: _____
Of Glasses of water/day: _____
Current Weight: ____ lbs
Ideal: ____ lbs

How Is Your Appetite?

❒ No appetite ❒ Nausea
❒ Weak ❒ Irregular
❒ Normal ❒ Strong
❒ Eating Disorder: _____
Anorexic Bulimic Binge Eating

How Does Food Affect You?

❒ Energized ❒ Satisfied
❒ Fatigued, Sleepy ❒ Unsatisfied

How Do You Eat?

❒ Snacking Frequently ❒On the Go
❒ Never Snack ❒ Sitting
❒ Mindfully ❒ Standing
❒ Over-eat ❒ Under-eat
❒ History of Dieting? if Y explain:
_____

Temperature Preferences:

❒ Hot Food ❒ Hot Drinks
❒ Cold Food ❒ Cold Drinks

Which Tastes Do You Prefer?

❒ Sweet ❒ Pungent
❒ Sour ❒ Bitter
❒ Salty ❒ Astringent

Is Your Thirst:

❒ No Thirst ❒ Dry Mouth
❒ Extreme ❒ Changeable

❒ List foods you avoid:

❒ List food allergies:

❒ Cravings For:

❒ Sweet Tooth:

Digestive Symptoms

❒ Abdominal Pain ❒ Gas
❒ Acid Reflux ❒ GERD
❒ Bad Breath ❒ Heartburn
❒ Belching ❒ Hiccups
❒ Bloating ❒ Ulcers
❒ Candida ❒ Vomiting
❒ Hypoglycemia ❒ Weight Loss
❒ Aggravated by Spices
❒ Nutritional Deficiencies

Is Your Diet:

❒ Non-Vegetarian (includes seafood)
❒ Pescetarian (seafood, no meat) ❒ Vegetarian (no meat or seafood)
❒ Vegan (no animals/animal product)
❒ Lactose Intolerant ❒ Gluten Free
❒ Raw Foods Diet ❒ Other:

Describe Diet:

Typical breakfast:

Typical lunch

Typical dinner:

Typical snacks:

Gastrointestinal Health

Bowel Movements:
Frequency: _____ /day _____ /week
Time of Day: _____
❒ Incomplete Evacuation
❒ Difficulty Passing Stools
❒ Constipation ❒ Diarrhea
❒ Dependent on Laxatives

Consistency of Stools:
❒ Normal (daily, same size/ shape)
❒ Unusually Hard ❒ Sink
❒ Unusually Soft ❒ Float
❒ Alternating Hard & Soft
❒ Smelly Stools ❒ Oily Stools
❒ Mucus in Stools ❒ Bloody Stools
❒ Undigested Food in Stools

Other Symptoms:
❒ Anal Fissures ❒ Colitis
❒ Crohn's Disease ❒ Diverticulosis
❒ Hemorrhoids ❒ Gallstones
❒ Rectal Prolapse ❒ Parasites
❒ Anal Itching/ Burning
❒ Intestinal Pain/ Cramping
❒ Irritable Bowel Syndrome IBS
❒ Other:

How Often Do You Eat The Following? # Times

Fruits	❒ Never	❒ Daily	❒ Weekly	_____
Vegetables	❒ Never	❒ Daily	❒ Weekly	_____
Carbohydrates	❒ Never	❒ Daily	❒ Weekly	_____
Grains	❒ Never	❒ Daily	❒ Weekly	_____
Protein	❒ Never	❒ Daily	❒ Weekly	_____
Dairy	❒ Never	❒ Daily	❒ Weekly	_____
Eggs	❒ Never	❒ Daily	❒ Weekly	_____
Meat	❒ Never	❒ Daily	❒ Weekly	_____
Fish/ Seafood	❒ Never	❒ Daily	❒ Weekly	_____
Fast Food	❒ Never	❒ Daily	❒ Weekly	_____
Organic	❒ Never	❒ Daily	❒ Weekly	_____
Sweets	❒ Never	❒ Daily	❒ Weekly	_____
Snacks	❒ Never	❒ Daily	❒ Weekly	_____
Nuts	❒ Never	❒ Daily	❒ Weekly	_____
Tea	❒ Never	❒ Daily	❒ Weekly	_____
Coffee	❒ Never	❒ Daily	❒ Weekly	_____
Soda	❒ Never	❒ Daily	❒ Weekly	_____

Health History Questionnaire

Pain Conditions

Rate Your Level Of Pain:
From 1 (mild) to 10 (severe) next to each type of pain you check.

Musculoskeletal/ Spinal
❒ Neck
❒ Upper Back
❒ Mid Back
❒ Lower Back

Joint Pain/ Swelling
❒ Shoulder
❒ Elbows
❒ Wrists
❒ Hands
❒ Hip
❒ Knees
❒ Ankles
❒ Foot
❒ Cracking of Joints

Other Conditions
❒ Arthritis type:
❒ Bursitis
❒ Carpal Tunnel Syndrome
❒ DJD Degenerative Joint Disease
❒ Fibromyalgia
❒ Gout
❒ Herniated Disk
❒ Multiple Sclerosis
❒ Muscle Cramping
❒ Muscle Spasms
❒ Neuropathy
❒ Numbness/ Tingling
❒ Osteoporosis
❒ Pelvic
❒ Pinched Nerve in Neck
❒ Plantar Fasciitis
❒ Sciatica
❒ Scoliosis
❒ Spinal Stenosis
❒ Tendonitis
❒ TMJ

❒ No Pain Anywhere

Headaches
How long ago did they start?

_____

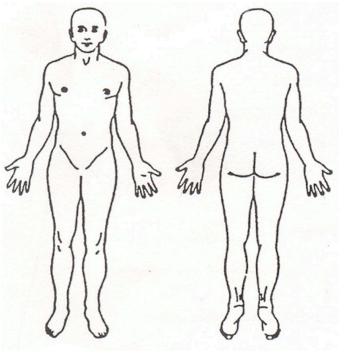
Frequency_____

Location:
❒ Vertex- Top of Head
❒ Occipital- Back of Head
❒ Entire Head
❒ Forehead
❒ Pressure Behind Eyes
❒ Sinuses
❒ Temples
❒ One-Sided
❒ Migraines
❒ Cluster
❒ Triggered by Weather

Accompanying Symptoms
❒ Nausea/ Vomiting
❒ Poor Mental Functions
❒ Visual Disturbances
❒ Dizziness/ Lightheaded
❒ Other:

Treatment for Pain
What have you tried so far?
❒ Surgery
❒ Nerve Blocks/ Injections
❒ Steriods
❒ Medications:
❒ Physical Therapy
❒ Chiropractor
❒ Massage

Pain Diagram: Mark areas with pain



Describe Nature Of Pain:
❒ Shifting/ Moving
❒ Fixed Position
❒ Dull/ Heavy/ Achy
❒ Distending
❒ Throbbing
❒ Sharp & Stabbing
❒ Cramping
❒ Burning
❒ Spontaneous
❒ Accompanied by Swelling
❒ Affected by Weather
❒ Radiates to _____
❒ Other

Onset
Related to any Activity? Y N
What Activity? _____
_____

Duration
❒ Constant, Steady
❒ Periodic, Intermittent
How long have you had the pain?
_____ yrs _____ months
When did it start? _____
Caused by Injury? Y N
What Injury? _____

Impact of Pain on Life?

Any Other Symptoms with Pain?

Pain Better / Worse With:
(*Checkmark if Better. Circle if worse.*)

❒ Pressure ❒ Massage
❒ Heat ❒ Cold
❒ Movement ❒ Rest
❒ Lying Down ❒ Sitting
❒ Medications ❒ Food

Health History Questionnaire

Review Of Symptoms & Conditions

Checkmark any current conditions/ symptoms or place an X in the box if you have experienced within past 6 months

Eyes	❒ Bloodshot ❒ Blurry ❒ Dry ❒ Floaters ❒ Grit ❒ Itchy ❒ Red ❒ Watery ❒ Eye Strain ❒ Sensitive To Light ❒ Cataracts ❒ Color Blind ❒ Glaucoma ❒ Pain/Pressure Behind Eyes ❒ Symptoms Related to Allergies ❒ Contacts/ Glasses: For _____ years ❒ Farsighted ❒ Nearsighted ❒ Decrease Night Vision
Ears	❒Earache ❒ Excess Earwax ❒ Loss of hearing ❒ Tinnitus- Ringing (high/ low pitch?) ❒ Sensitivity To Sound ❒ Wear Hearing Aids Since: _____
Nose	❒ Frequent Colds ❒ Congestion ❒ Runny nose: clear, white, yellow ❒ Post-Nasal Drip ❒ Loss of Smell ❒ Stuffy ❒ Deviated Septum ❒ Nasal Polyps ❒ Nosebleeds ❒ Sensitive to Smell ❒ Sinus Pain ❒Sinusitis How frequent? _____ ❒ Other _____ ❒ Do you use neti pot? Y N
Throat	❒ Dry throat/ mouth ❒ Hoarse Voice ❒ Itchy ❒ Sore ❒ Strep ❒ Excess Saliva ❒ Mouth/ Tongue Sores ❒ Difficulty Swallowing ❒ Swollen Glands
Teeth	❒ Cavities ❒ Loose ❒ Sensitive ❒ TMJ Pain: R or L side ❒ Do you wear a mouth guard? Y N
Gums	❒ Bleeding ❒ Gingivitis ❒ Receding ❒ Sores/ Ulcers ❒ Tender ❒ Gum Disease ❒ Other _____
Hair	❒ Dandruff ❒ Dry ❒ Hair Loss ❒ Oily ❒ Normal ❒ Falls Out Easily
Nails	❒ Brittle, Break Easily ❒ Dry, Rough ❒ Ridged ❒ Oily ❒ Pale ❒ Pink ❒ Smooth
Skin	❒Acne ❒ Boils ❒ Bruises easily ❒ Clammy ❒ Dry ❒ Eczema ❒ Fungal Infections ❒ Itching ❒ Psoriasis ❒ Rashes/Hives ❒ Rosacea ❒ Sensitive ❒ Scars ❒ Skin Eruptions ❒ Sunburn Easily ❒ Use Sunblock? Y N
Perspiration	❒ Spontaneous or w/o Exertion ❒ Excessive ❒ Rarely ❒ Nighttime Sweats ❒ Cold Sweats ❒ Unusual Odor
Body Temp	❒ Hot- whole body ❒ Cold- whole body ❒ Cold- hands and feet ❒ Chills / Fever ❒ Normal
Circulation	❒ Blood clots ❒ Poor circulation ❒ Edema ❒ Swollen ankles ❒ Varicose veins ❒ Other _____
Sleep	Hours per night _____ Time to bed _____ Time to wake _____ ❒ Fall Asleep Easily ❒ Trouble Falling Asleep ❒ Interrupted sleep, if so what time? _____ ❒ Trouble Going Back to Sleep ❒ Restless Sleep ❒ Light Sleeper ❒ Deep Sleeper ❒ Excessive Sleep ❒ Sleep Apnea ❒ Tendency to Snore ❒ Drowsiness ❒ Napping during daytime ❒ Rested When Wake Up ❒ Trouble Waking Up ❒ Sleep walking ❒ Excessive Dreams ❒ Nightmares, how often? _____ any theme? _____
Respiration Immunity	❒ Asthma ❒ Allergies ❒ Use Inhaler, how often? _____ ❒ Bronchitis ❒ Emphysema ❒ Pneumonia ❒ Cough ❒ Cough w/blood or phlegm ❒ Shortness Of Breath ❒ Tuberculosis ❒ Wheezing ❒ Low Immunity ❒ Strong Immunity, don't get sick often ❒ Autoimmune Disorder: _____ ❒ AIDS/ HIV ❒ Hepatitis ❒ Hemophilia ❒ Lupus ❒ Cancer, what type? _____
Cardio-vascular	❒ Arteriosclerosis ❒ Chest Pain ❒ Coronary Disease ❒ Heart Murmur ❒ Heaviness or Tightness In Chest ❒ High Cholesterol ❒ High BP ❒ Low BP ❒ Hypertension ❒ Hypotension ❒ Congenital Heart Defect ❒ Pacemaker ❒ Palpitations if so how often? _____ ❒ Irregular heart beat ❒ Slow Pulse ❒ Fast Pulse
Urination	Frequency: _____/ day Color: _____ ❒ Nighttime- # of Times at Night _____ ❒ Bedwetting ❒ Normal ❒ Bloody ❒ Burning ❒ Clear ❒ Cloudy ❒ Dribbling ❒ Foamy ❒ Frequent ❒ Painful ❒ Profuse ❒ Retention ❒ Sandy/ Gritty ❒ Scanty ❒ Urgent ❒ Kidney/Bladder Infections ❒ Kidney Stones ❒ Congenital Kidney Problems ❒ Urinary Tract Infections (UTI)
General	❒ Anemia ❒ Appendicitis ❒ Bleeding Disorders ❒ Chemical Dependency ❒ Convulsions/ Seizures ❒ Gout ❒ Diabetes ❒ Stroke ❒ Dizziness/ Lightheadedness ❒ Fainting ❒ Goiter ❒ Hepatitis ❒ Hernia ❒ Jaundice ❒ Liver Problems ❒ Multiple Sclerosis ❒ Paralysis ❒ Parkinson's ❒ Thyroid Disorders ❒ Genetic Disorders

Health History Questionnaire

Women's Health Only

Libido- is your sexual energy:
❒ Low ❒ Normal ❒ High

Sexual Activity
❒ Abstinent ❒ Infrequent
❒ Variable ❒ Frequent
❒ Painful Intercourse

Birth Control
❒ Pills ❒ Patch ❒ Diaphragm
❒ IUD ❒ Injection ❒ Condoms
❒ Rhythm Method

Pregnancy
❒ Currently Pregnant Week _____
# of Pregnancies: _____
# of Abortions: _____
# of Miscarriages: _____
# of Childbirths: _____
❒ History of Post-Partum Depression
❒ Complications: _____
_____
_____
_____
_____
_____
_____

Infertility diagnosis? Y N
Diagnosis: _____
How long ago? _____
How long have you been with your partner? _____
How long have you been trying to conceive? _____
Have you had fertility tests? Y N
Date: _____
Results _____
Has he had fertility tests? Y N
Date: _____
Results _____
Tubal operations? Y N
Date: _____
Hormone laboratory tests? Y N
Date: _____
Results _____

Menstrual Cycle
Age Started:
Date of Last Menses: / /
Date of Last OBGYN exam: / /

# of Days in Cycle _____ (28?)
# of Days in Flow _____ (3-7?)

Color: ❒ Bright Red ❒ Dark Red
❒ Rust ❒ Brown ❒ Pale
Flow: ❒ Light ❒ Medium ❒Heavy

❒ Clots, how big? _____
❒ Irregular, how frequent? ____
❒ Spotting, when? _____
❒ Cramps, how many days? ___
❒ No Period- Amenorrhoea
❒ Painful periods- Dysmenorrhea
❒ Skipped Cycles since _____
Ovulation: ❒ Painful ❒ None

PMS Signs / Symptoms:
When does it start? _____
❒ Acne
❒ Bloating
❒ Breast Tenderness/ Swelling
❒ Constipation
❒ Diarrhea
❒ Fatigue
❒ Food cravings for:
❒ Headache/ Migraine
❒ Irritable
❒ Low Back Pain
❒ Mood Changes
❒ Nausea/ Vomiting

Other Symptoms:
❒ Abnormal Pap Smear
❒ Cancers, what kind?
❒ Cysts Location:
❒ Endometriosis
❒ Fibrocystic Breasts
❒ Fibroids Uterine
❒ Hysterectomy
❒ Pelvic Adhesions
❒ Pelvic Inflammatory Disease (PID)
❒ Polyps- uterine or cervical
❒ Sexually Transmitted Diseases
Type: _____

Surgeries:
❒ Tubal Ligation ❒ D&C
❒ Other: _____
_____

Vaginal Discharges
❒ Liquid ❒ White ❒ Yellow
❒ Thick Bad ❒ Odor
❒ Yeast infections often? Y N
❒ Vaginal Dryness
❒ Other: _____

Menopause
Age At Onset: _____, _____ yrs
❒ Hot Flashes Frequency _____
❒ Night Sweats Frequency _____
❒ Hormone Replacement Therapy
For How Long?
❒ Other _____

Men's Health Only

Libido- is your sexual energy: ❒ Low ❒ Normal ❒ High

Sexual Activity ❒ Abstinent ❒ Infrequent ❒ Variable ❒ Frequent
❒ Painful Intercourse ❒ Use Condoms Regularly
❒ Sexually Transmitted Diseases Type: _____
❒ Impotence ❒ Erectile Dysfunction ❒ Premature Ejaculation ❒Vasectomy
❒ Seminal Emission ❒ Prostate Problems ❒ Swollen Testes
❒ Testicular Pain ❒ Other ❒ Infertility Diagnosis: