

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome _____

What types of therapy have you tried for this problem(s):

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
 other _____

List current health problems for which you are being treated: _____

Current medications (prescription or over-the-counter): _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? _____

- Corrective lenses Dentures Hearing aid Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: see hear taste smell feel hot/cold sensations

- move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Strong dislike for any one of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Do you: Prefer warmth (i.e., food, drinks, weather, etc.) Prefer cold (i.e., food, drinks, weather, etc.) No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

Time of day you feel the worst or your symptoms are aggravated:

- 7 a.m. - 9 a.m. 9 a.m. - 11 a.m. 11 a.m. - 1 p.m.
 1 p.m. - 3 p.m. 3 p.m. - 5 p.m. 5 p.m. - 7 p.m.
 7 p.m. - 9 p.m. 9 p.m. - 11 p.m. 11 p.m. - 1 a.m.
 1 a.m. - 3 a.m. 3 a.m. - 5 a.m. 5 a.m. - 7 a.m.

- 7 a.m. - 9 a.m. 9 a.m. - 11 a.m. 11 a.m. - 1 p.m.
 1 p.m. - 3 p.m. 3 p.m. - 5 p.m. 5 p.m. - 7 p.m.
 7 p.m. - 9 p.m. 9 p.m. - 11 p.m. 11 p.m. - 1 a.m.
 1 a.m. - 3 a.m. 3 a.m. - 5 a.m. 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
 Depression Panic attacks Nausea Fecal incontinence Bleeding
 Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
 Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash