Health History Questonnaire Part 1

NAME ____ Date _________________________

Date of Birth _________________________ Age ____ Sex ____ Height ____ Weight ________

Referred by / How did you hear about us? ____

Marital Status: Single, Married / Partnered, Divorced / Separated, Widowed

Occupation ____ How long ______________

Name of Spouse / Partner ____

Number of Children: Boys _____ Ages _______ Girls _____ Ages _______

When were you last seen by a physician and for what purpose? ____

Health issues you would like help with now, and what other treatments & results have you had for these issues:

1____

2____

3____

List current medications: Indicate response to medication (if not already mentioned above):

____________________________________ ______________________________________

____________________________________ ______________________________________

____________________________________ ______________________________________

Current supplements or over-the-counter items: Indicate response to supplements

____________________________________ ______________________________________

____________________________________ ______________________________________

____________________________________ ______________________________________

List known allergies to either food or drugs: ____

____

YOUR HISTORY: Check all of the conditions that you have had in the past.

__Alcoholism	__Emphysema/Asthma	__Muscle Problems	Thyroid:Hypo__ Hyper__
__Arthritis	__Epilepsy/Seizures	__Neurological Issue	__TMJ/Jaw Dysfunction
__Anxiety/Depression	__Eye Issues	__Pain __Psychological Issues	__Herpes __CMV
__Autoimmune Disease	__Genetic Condition	__Respiratory Issues	__Polio __Mono
__Bladder/Kidney	__Headaches	__Rheumatic Fever	__Weight Loss:
__Cancer	__Heart Disease __Hepatitis	__Scarlet Fever	How much ___Time?____
__Digestive Issues	__High Blood Pressure	__Sexually Trans Dis.	__Weight Gain:
__Diabetes	__HIV/AIDS	__Sinus/Upper Resp.	How much___ Time?____
__Ear Infections/Issues	__Hormonal Issues	__Stroke	__Other:_______________
__Eczema/Skin Issues	__Intestinal Issues	__Swallowing Issues	______________________

Any significant accidents, injuries or illnesses? Describe: _________________________________
____

List any other hospitalizations or surgeries you have had, and your age at the time:
____

Did you have any of the following childhood diseases?
Measles Mumps Chicken pox Frequent Ear Infections Rashes Mono

List any unusual childhood illnesses: ____
____

FAMILY HISTORY: Check all conditions that have affected your parents, grandparents, siblings & children

CONDITION	Relatives/s Affected	CONDITION	Relatives/s Affected
Addiction(s)	____________________	Genetic Disease	____________________
Allergies	____________________	Gout	____________________
Arthritis	____________________	Headache/Migraine	____________________
Asthma	____________________	Heart Disease	____________________
Bladder/Kidney	____________________	High Blood Pressure	____________________
Bleeding Issues	____________________	Lung Issues	____________________
Cancer	____________________	Overweight	____________________
Depression	____________________	Stroke	____________________
Diabetes	____________________	Thyroid Disease	____________________
Digestive	____________________	Intestinal Issues	____________________
Suicidal/Suicide	____________________		

Is your mother still alive? Yes / No If not, age at death? _____ What was the cause of death?
____

Is your father still alive? Yes / No If not, age at death? _____What was the cause of death?
____

If any of your siblings have died, please give their ages and the cause of death: _____________
____

ACTIVITY LEVEL:
__Sedentary (inactive) by choice
__Sedentary (inactive) due to inability or restriction
__Light: light daily work w/no regular exercise
__Moderate: light daily work and exercise 3X/week
__Sustained: moderate daily work & exercise 5X/week

STRESSES AFFECTING YOUR LIFE:
__Difficulties with work or lifestyle
__Recent change in marital status / relationship issues
__Death or serious illness of family or friend
__Dysfunctional family __Past __Present
__Lack of love or fulfilling relationship(s)
__Illness - self

How often do you feel fatigue? ____

What time of day are you the most tired? ____

Do you experience undue worry, difficulty concentrating or forgetfulness? If yes, describe.
____

Circle the items that you use? Indicate how much and how often?
Water ____
Tea ____
Coffee ____
Alcohol ____
Soda (regular or diet)____
Cigarettes ____
Laxatives ____
Sugar ____
Artificial Sweeteners ____

Other Substances ____

Please describe your average daily diet:
B: ____
L: ____
D: ____

List foods that you crave ____
____

Describe any special dietary restrictions: ____
____