



Health History

PERSONAL INFORMATION

Name: _____ Date: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Soc. Sec. No.: _____ Date of birth: _____

Marital status: _____ Sex: _____ Age: _____ Number of children: _____

Occupation: _____ Employer: _____

Address: _____ City/Zip: _____ Phone: _____

Name of spouse: _____ Spouse's Occupation: _____

Employer: _____

Address: _____ City/Zip: _____ Phone: _____

EMERGENCY NOTIFICATION

Name: _____

Address: _____ City/Zip: _____ Phone: _____

Referred by: _____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Date: _____ Patient's Signature: _____

CURRENT HEALTH CONDITION

Primary Purpose of this consultation: _____

HABITS

- Alcohol: Type _____
 Amount _____
 Diet: Salt intake _____
 Fat intake _____
 Other _____
- Sleep: Difficulty falling asleep _____
- Continuity disturbances _____
 Early morning awakenings _____
 Daytime drowsiness _____
 Other _____
- Smoking: Packs daily _____
 How long _____
 Interested in stopping? _____
- Exercise routine: _____

- Caffeine: Coffee, cups daily _____
 Other _____

MEDICATIONS: _____

DRUG ALLERGIES: _____

SUPPLEMENTS TAKEN DAILY: _____

MEDICAL HISTORY

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> RINGING IN EAR _____ | <input type="checkbox"/> GALL BLADDER TROUBLE _____ | <input type="checkbox"/> TREMOR/HANDS SHAKING _____ | MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> EAR INFECTIONS - FREQUENT _____ | <input type="checkbox"/> JAUNDICE/HEPATITIS _____ | <input type="checkbox"/> MUSCLE WEAKNESS _____ | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES |
| <input type="checkbox"/> DIZZINESS/FAINTING _____ | <input type="checkbox"/> CHANGE IN BOWEL HABITS _____ | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FAILING VISION _____ | <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION _____ | <input type="checkbox"/> HEADACHES - FREQUENT _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE INFECTIONS _____ | <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS _____ | <input type="checkbox"/> ARTHRITIS/RHEUMATISM _____ | Females - Please Complete |
| <input type="checkbox"/> NOSE BLEEDS _____ | <input type="checkbox"/> BLOODY OR TARRY STOOLS _____ | <input type="checkbox"/> OSTEOPOROSIS _____ | PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> SINUS TROUBLE _____ | <input type="checkbox"/> HEMORRHOIDS _____ | <input type="checkbox"/> BACK PAIN - RECURRENT _____ | PLANNING PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> SORE THROATS - FREQUENT _____ | <input type="checkbox"/> HERNIA _____ | <input type="checkbox"/> BONE FRACTURE/JOINT INJURY _____ | Menstrual Flow: |
| <input type="checkbox"/> HAYFEVER/ALLERGIES _____ | <input type="checkbox"/> URINE INFECTIONS - FREQUENT _____ | <input type="checkbox"/> GOUT _____ | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> PNEUMONIA _____ | <input type="checkbox"/> BLOOD IN URINE _____ | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET _____ | ____ Days of Flow ____ Length of Cycle |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH _____ | URINATION- <input type="checkbox"/> OVERNIGHT > THAN TWICE | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES _____ | Date-1st day of last period _____ |
| <input type="checkbox"/> ASTHMA/WHEEZING _____ | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA _____ | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> CHEST PAIN _____ | <input type="checkbox"/> DECREASE IN FORCE/FLOW | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION _____ | Number of: |
| <input type="checkbox"/> HIGH BLOOD PRESSURE _____ | <input type="checkbox"/> KIDNEY STONES _____ | <input type="checkbox"/> MEMORY LOSS _____ | ____ Pregnancies ____ Abortions |
| <input type="checkbox"/> HEART MURMUR _____ | <input type="checkbox"/> VENEREAL DISEASE _____ | <input type="checkbox"/> MOODINESS - EXCESSIVE _____ | ____ Miscarriages ____ Live Births |
| <input type="checkbox"/> SWOLLEN ANKLES _____ | <input type="checkbox"/> URETHRAL DISCHARGE _____ | <input type="checkbox"/> PHOBIAS _____ | Birth Control Method _____ |
| <input type="checkbox"/> LEG PAIN - WALKING _____ | <input type="checkbox"/> CHRONIC FATIGUE _____ | <input type="checkbox"/> MENTAL ILLNESS _____ | B.C. Pill (Name) _____ |
| <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS _____ | <input type="checkbox"/> WEIGHT LOSS - RECENT _____ | <input type="checkbox"/> LACTOSE INTOLERANCE _____ | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> LOSS OF APPETITE _____ | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY _____ | <input type="checkbox"/> PROSTATE DISEASE _____ | Date of Last PAP Test _____ |
| <input type="checkbox"/> DIFFICULTY SWALLOWING _____ | <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> INDIGESTION OR HEARTBURN _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> FREQUENT INFECTIONS _____ | Date of Last Mammogram _____ |
| <input type="checkbox"/> PERSISTENT NAUSEA/VOMITING _____ | <input type="checkbox"/> THYROID DISEASE _____ | <input type="checkbox"/> DIPHTHERIA _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> PEPTIC ULCERS _____ | <input type="checkbox"/> CONVULSIONS/SEIZURES _____ | <input type="checkbox"/> TETANUS _____ | |
| <input type="checkbox"/> ABDOMINAL PAIN - CHRONIC _____ | <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS <input type="checkbox"/> | |

HOSPITALIZATIONS

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY				HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP	
Relationship	Age if living	Age at death	State of health or cause of death	Illness	Family member
Father				Diabetes	
Mother				Cancer	
Brothers and sisters				Blood disease	
				Glaucoma	
				Epilepsy	
				Rheumatoid arthritis	
				Tuberculosis	
Spouse				Gout	
				High blood pressure	
Children				Heart disease	
				Back problems	