Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Acupuncture ☐ Chiropractic ☐ None ☐ Other _____

If so, Name and Address of doctor(s) who have treated you for your condition _____

_____

Please mark C for a current condition, P if a past condition and leave blank if not applicable.

____ADD/ADHD	____Depression	____Kidney Stone	____Psychiatric Care
____AIDS/HIV	____Diabetes	____Knee Pain	____Rheumatic Fever
____Anemia	____Dizziness	____Leg Pain	____Scarlet Fever
____Anorexia	____Epilepsy	____Liver Disease	____Sciatica
____Anxiety	____Fainting	____Low Back Pain	____Seizures
____Appendicitis	____Fibromyalgia	____Mid Back Pain	____Shingles
____Arm Pain	____Gall Stones	____Migraine Headaches	____Shoulder Pain
____Arthritis	____Goiter	____Miscarriage	____Sinus Congestion
____Asthma	____Gout	____Mononucleosis	____STDs
____Bronchitis	____Headaches	____Multiple Sclerosis	____Stroke
____Bulimia	____Heart Disease	____Mumps	____Thyroid Problems
____Cancer	____Hepatitis	____Neck Pain	____Tonsillitis
____Carpal Tunnel	____Hernia	____Night Sweats	____Tuberculosis
____Celiac Disease	____Herniated Disc	____Numbness or Tingling	____Tumors/Growths
____Chest Pain	____Herpes	____Osteoporosis	____Ulcerative Colitis
____Chicken Pox	____High Cholesterol	____Pacemaker	____Ulcers
____Chronic Fatigue	____Hypertension	____Parkinson's Disease	____Upper Back Pain
____Cold Sores	____Irritable Bowel Disease	____Pinched Nerve	____UTI
____Concussions	____Infertility	____Pneumonia	____Vaginal Infection
____Cough	____Jaw Pain	____Polio	____Whooping Cough
____Crohn's Disease	____Kidney Infection	____Prostate Problems	

Others not listed above _____

Allergies: ☐ Dust ☐ Mold ☐ Trees ☐Weeds ☐ Grass ☐Animal ☐ Perfume ☐ Smoke ☐ Foods (list on next page)

☐ Others not listed above _____

Descriptions & Dates on the following:

Hospitalizations/Surgeries you have had _____

Auto Accidents_____

Recent Infections (Cold, Flu etc) _____

Falls/Injuries _____

Fractures/Dislocations _____

Medications _____

Vitamins/Supplements _____

Please list family history of any diseases or conditions _____

Social and Occupational History

Diet: Food Cravings: ☐ Sweets ☐ Salt ☐ Sour ☐ Bitter ☐ Spicy

☐ Alcohol (type/drinks per week) _____

☐ Sugar (type/amount per day) _____

☐ Caffeine (type/drinks per day) _____

☐ Tobacco (type/amount per day) _____

Typical Breakfast: _____

Mid-Morning Snack: _____

Typical Lunch: _____

Afternoon Snack: _____

Typical Dinner: _____

Typical Beverages: _____

Favorite Foods: _____

Food Allergies: ☐ No ☐ Yes (please list) _____

_____

Females Only: Total length of cycle _____ Length of Menses _____ Menses: ☐ Heavy ☐ Moderate ☐ Light

☐ PMS ☐ Mood Swings ☐ Cramping ☐ Breast Tenderness ☐ Pregnant ☐ Post Menopausal

Gastrointestinal: ☐ Excess Hunger ☐ Poor Appetite ☐ Nausea ☐ Hemorrhoids ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Gas

☐ Bloating ☐ Strong Smell # of Bowel Movements/Day _____

Sleep: Hours per night _____ Quality: ☐ Poor ☐Fair ☐Good ☐Trouble Falling Asleep ☐Staying Asleep ☐ Insomnia

At what time do you wake up _____ How many times do you wake up _____

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach ☐ All

Urination: ☐ Excess urination ☐ Frequent urination ☐ Painful urination Night Urination: how many times? _____

Job activities include: _____

_____

Physical activity at work ☐ Sedentary ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor

How long do you speak on the telephone each day _____ ☐ Traditional receiver ☐ Headset

Do any of your work activities aggravate your present main complaints? Please Describe: _____

_____

Stress Level: ☐ Mild ☐ Moderate ☐ Severe

Reason: _____

How do you handle stress? ☐ Exercise ☐ Sleep ☐ Eat ☐ Other _____

Energy Level: 0 1 2 3 4 5 6 7 8 9 10 Time of Lows _____

Exercise: 1. Type _____ Frequency _____

2. Type _____ Frequency _____

3. Type _____ Frequency _____