Health History Form

All information is strictly confidential.

Client Name: _____ **Today's Date:** _____

I. Major Complaint(s), in order of significance:

	Severe	Moderate	Slight	
1.	❑	❑	❑	_____
2.	❑	❑	❑	_____
3.	❑	❑	❑	_____

How do the above conditions impair your daily activities? _____

_____

II. Patient Medical History:

Please list any medications you are taking, or have taken, and for how long (attach separate sheet if necessary)

Medications	Reason for Taking	Date Started/Stopped	Dosage

Prescribing Physician name: _____ List medications you are allergic to: _____

Briefly list all major past illnesses, hospitalizations, surgeries, operations, fractures, car accidents or major trauma you have experienced. Include date, outcome, etc.

Illnesses: _____

Trauma: _____

Check off any of the below surgeries you have had:

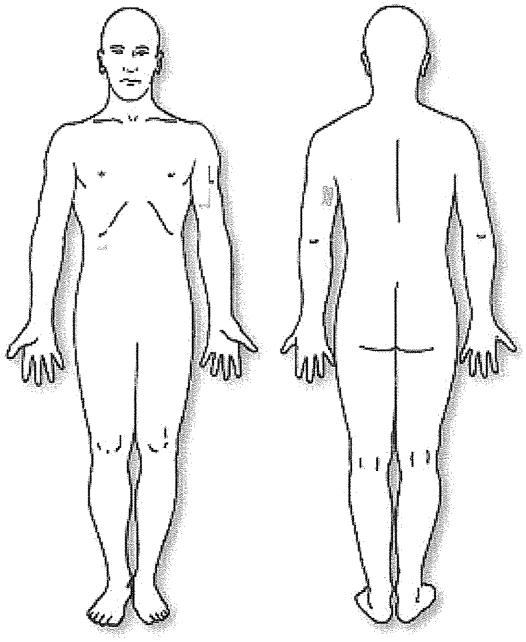
❑ Appendectomy	❑ Biopsies	❑ Dental Surgery	❑ Gallstones	❑ Implants/Prostheses
❑ Arthroscopy	❑ Cholecystectomy	❑ Eye Surgery	❑ Hysterectomy	❑ Kidney Stones
❑ Breast Implants	❑ C-Section	❑ Fracture	❑ Hernia	❑ Laparoscopy ❑ Other

Surgeries or Operations: _____

Other major illnesses you have had: _____

III. Pain & Scars

Please clearly mark any problem areas with an "x" and any scars with an "s"



If you have pain, is it:

❑ Sharp ❑ Burning ❑ Aching ❑ Cramping
❑ Dull ❑ Moving ❑ Fixed ❑ Constant
❑ Intermittent ❑ Other:_____

Do the following lessen the pain?

❑ Pressure ❑ Cold ❑ Ice ❑ Heat
❑ Dampness ❑ Dryness ❑ AM ❑ PM
❑ Exercise ❑ Other:_____

Do the following worsen the pain?

❑ Pressure ❑ Cold ❑ Ice ❑ Heat
❑ Dampness ❑ Dryness ❑ AM ❑ PM
❑ Exercise ❑ Other:_____

Specific movements or activities that aggravate the pain_____

Does this condition affect your sleep in any way? ❑ Yes ❑ No

How bad is your pain currently on a scale from 1-10 (1 = no pain, 10 = unbearable pain):

1 2 3 4 5 6 7 8 9 10

IV. Family Medical History

Please list (and specify if necessary) any condition that you or a member of your family has experienced.

	Self	Mother/Father	Brother/Sister	Child	Grandparent Maternal/Paternal	Aunt/Uncle
Alcohol/Drug Abuse						
Allergies/Sinus						
Anemia/Blood Disorder						
Arthritis						
Birth Defect						
Cancer/Type						
Diabetes						
Depression/Anxiety						
Mental Health Disorder						
High Cholesterol						
Heart Disease						
High Blood Pressure						
Obesity						
Thyroid Disorder						
Stroke						
Other						

Were you breast-fed as a child: ❑ Yes ❑ No ❑ Unsure

IV. Dietary Assessment

Please check the boxes in regards to how often you eat or drink the listed types of foods.

	More than Once Daily	Daily	3 Times per week	Once per week	Twice a month	Less or Never
Grains, Breads, Cereals	❑	❑	❑	❑	❑	❑
Milk & Dairy Products	❑	❑	❑	❑	❑	❑
Eggs	❑	❑	❑	❑	❑	❑
Meat, Poultry, Fish	❑	❑	❑	❑	❑	❑
Beans, Peas & Legumes	❑	❑	❑	❑	❑	❑
Fruits	❑	❑	❑	❑	❑	❑
Vegetables	❑	❑	❑	❑	❑	❑
Soy Products	❑	❑	❑	❑	❑	❑
Nuts & Seeds	❑	❑	❑	❑	❑	❑
Popcorn & Chips	❑	❑	❑	❑	❑	❑
Spicy Food	❑	❑	❑	❑	❑	❑
Chocolate	❑	❑	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑	❑	❑
Soda, Sugar or Candy	❑	❑	❑	❑	❑	❑
Fast Food	❑	❑	❑	❑	❑	❑

Are you on a special diet? ❑ Yes ❑ No If yes, please describe: _____

Do you have any known food allergies, sensitivities or intolerances (ie lactose, gluten)? ❑ Yes ❑ No

If yes, please describe: _____

Please list any supplements you are taking, or have taken, and for how long:

Vitamin/Mineral/Supplement	Reason for Taking	Date Started	Dosage

V.Lifestyle (Sleep, Exercise, Stress)

Rate your sleep quality. Check all that apply

❑ Wake up tired ❑ Nightmares ❑ Restless Legs ❑ Bruxing ❑ Other: _____

❑ Sleep Apnea ❑ Snoring ❑ Difficulty falling asleep ❑ Wake up during the night (usually at: ____)

What time do you usually go to sleep? _____ How many hours do you sleep per night on average? _____

Do you exercise? ❑Yes ❑No If yes, what type of exercise?

❑ Walking ❑ Spinning ❑ Marathon (full / half / frequency per year: _____)
❑ Running ❑ Dance ❑ Martial Arts (please specify: _____)
❑ Weightlifting ❑ Aerobics ❑ Team Sports
❑ Triathlon ❑ Cross Fit ❑ Kettle Bell Training
❑ Biking ❑ General Cardio ❑ Other: _____

How often do you exercise: ❑ 1-2 times per week ❑ 3-4 times per week ❑ 5+ times per week

How long is your average exercise session? ❑ 30 min ❑ 60 min ❑ 90 min ❑ over 90 min

VI. Additional Health Information

Women only:

Regular menstrual cycle? ❑ Yes ❑ No
Avg. number of days (period to period): _____

Flow is: ❑ Heavy ❑ Light ❑ None
Days of flow: 1 2 3 4 5 6 7+

Menstrual Cramps
❑ Mild ❑ Moderate ❑ Severe

Frequency of cramps:
❑ Monthly ❑ Other (describe how often):_____

❑ Pre-menstrual syndrome (PMS). If yes, check symptoms that apply:
❑ Food cravings ❑ Irritability ❑ Water retention ❑ Breast swelling/tenderness
❑ Crying easily ❑ Headaches ❑ Migraines ❑ Other: _____

❑ Birth Control Pill Use — Date started: _____ Date stopped: _____
❑ Bleeding between periods
❑ Abnormal PAP smear — What class? _____ Date of last PAP smear: _____
❑ Vaginal discharge
❑ Menopausal Symptoms — Which?_____
❑ Spotting — ❑ During period ❑ Between periods
❑ Painful Intercourse — ❑ Past ❑ Present
❑ Breast Lumps/Fibrocystic — ❑ Past ❑ Present
❑ Vaginal Infections/Yeast — ❑ Past ❑ Present — How many times per year: _____
❑ Sexual Dysfunction — ❑ Past ❑ Present
Describe: _____
❑ Infertility — ❑ Past ❑ Present
Treatments: _____

Men only:

❑ Benign prostatic hypertrophy (BPH) ❑ nausea Completed TURP; Date(s)_____
❑ Testicular pain
❑ Erectile Dysfunction
❑ Premature ejaculation
❑ Feeling of coldness or numbness in external genitalia
❑ Urinary Difficulty/pain
❑ Other_____

Other Comments:

_____

_____

_____

_____

Please sign and date:

Print name:

Signature: **Date:**