

Health History Questionnaire

Date: _____

This information is for the diagnosis procedure and helps us to provide you with a better treatment. Please fill it out as accurately as you can. This information is confidential.

Name (First and Last)	Best phone number(s) for contact	Email	
Street	City	State/Zip	
Date of Birth (mm/dd/yy) / /	Occupation	Height	Weight
Emergency Contact Name:	Phone - -	Marital Status	
Family Physician	Phone - -	Referred by	

Main problems you would like to address:

What treatments have you tried?

Medicines:

Allergies:

Surgeries:

Exercise:

Please describe your average daily diet:

Morning:

Afternoon:

Evening:

Habits (please circle): Smoking Caffeine Alcohol Non-medicinal drugs

Past Medical History:

Family Medical History:

	Yes	No	Date		Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		Other (Please describe):		
Other (Please describe:)						

General Health

	Yes	No		Yes	No
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Sweat easily	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Bleed or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Strong thirst (hot or cold drinks)	<input type="checkbox"/>	<input type="checkbox"/>
Peculiar tastes or smells	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Sudden energy drop	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Poor sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Cravings	<input type="checkbox"/>	<input type="checkbox"/>
Heavy limbs	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>

Skin and Hair

	Yes	No		Yes	No
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Pimples	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Recent moles	<input type="checkbox"/>	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Change in hair or skin texture	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)					

Head, Eyes, Ears, Nose Throat

	Yes	No		Yes	No
Poor vision	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent sore throats	<input type="checkbox"/>	<input type="checkbox"/>
Eye strain	<input type="checkbox"/>	<input type="checkbox"/>	Sores on lips or tongue	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Night blindness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
Concussions	<input type="checkbox"/>	<input type="checkbox"/>	Color blindness	<input type="checkbox"/>	<input type="checkbox"/>
Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Spots in front of your eyes	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain	<input type="checkbox"/>	<input type="checkbox"/>	Ear-aches	<input type="checkbox"/>	<input type="checkbox"/>
Jaw clicks	<input type="checkbox"/>	<input type="checkbox"/>	Poor hearing	<input type="checkbox"/>	<input type="checkbox"/>
Teeth problems	<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe)					

Cardiovascular (heart and circulation)

	Yes	No		Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	Vein pain / swelling	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of hands/feet	<input type="checkbox"/>	<input type="checkbox"/>			
Other cardiovascular (please describe)					

Respiratory (lungs)

	Yes	No		Yes	No
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Pain with deep breath	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>			
Other respiratory (please describe)					

Gastrointestinal (stomach and intestines)

	Yes	No		Yes	No
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>	Chronic laxative use	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Other gastrointestinal (please describe)					

Genito-urinary

	Yes	No		Yes	No
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Night urination	<input type="checkbox"/>	<input type="checkbox"/>
Urgency to urinate	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in flow	<input type="checkbox"/>	<input type="checkbox"/>	Genital sores	<input type="checkbox"/>	<input type="checkbox"/>
Other genital/urinary (please describe)					

Musculoskeletal (bone, joint and muscle)

	Yes	No		Yes	No
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Foot/ankle	<input type="checkbox"/>	<input type="checkbox"/>
Hand/wrist	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>
Muscle	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Other musculoskeletal (please describe)					

Neuropsychological

	Yes	No		Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	<input type="checkbox"/>
Areas of numbness	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Lack of coordination	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Bad temper	<input type="checkbox"/>	<input type="checkbox"/>
Easily susceptible to stress	<input type="checkbox"/>	<input type="checkbox"/>			
Have you ever been treated for emotional problems?				<input type="checkbox"/>	<input type="checkbox"/>
Have you ever considered or attempted suicide?				<input type="checkbox"/>	<input type="checkbox"/>
Any other neurological or psychological problems?				<input type="checkbox"/>	<input type="checkbox"/>

Reproductive and Gynecological

	Yes	No
Number of pregnancies	<input type="checkbox"/>	<input type="checkbox"/>
Abortions	<input type="checkbox"/>	<input type="checkbox"/>
Live births	<input type="checkbox"/>	<input type="checkbox"/>
Premature births	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>
Age of first menses	<input type="checkbox"/>	<input type="checkbox"/>
Last menstrual period	<input type="checkbox"/>	<input type="checkbox"/>
Length of cycle	<input type="checkbox"/>	<input type="checkbox"/>
Duration of menses	<input type="checkbox"/>	<input type="checkbox"/>
Last pap	<input type="checkbox"/>	<input type="checkbox"/>
Changes in psyche/body prior to menstruation: If yes, please describe:	<input type="checkbox"/>	<input type="checkbox"/>