



Health History Questionnaire

Please help us provide you with a complete evaluation by carefully filling out this questionnaire. All of your answers will be held *absolutely confidential*. If you have questions, please ask. Thank you.

Name _____ Age _____ M F Today's Date (Mo/Day/Year) _____

E-mail Address _____ Birth Date (M/D/Y) _____

Home Address _____ City _____ Postal Code _____

Occupation _____ Home Phone _____ Cell Phone _____

Preferred method of communication: Home Phone Cell Phone Email

Spouse's Name _____ Children (Name/Age) _____

Names of Other Healthcare Providers:

Naturopathic Doctor _____

Massage Therapist _____

Medical Doctor _____

Chiropractor _____

Specialist(s) _____

Other _____

How did you find out about our clinic? _____

Current Health Concern(s) and Goals, in priority:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

When did your problem(s) begin (be specific)? _____

Have you been given any diagnosis? If so, what? _____

What measures have you taken to improve your problem(s)? _____

Current Supplements and/or Medications

- 1) _____ Dosage: _____
- 2) _____ Dosage: _____
- 3) _____ Dosage: _____
- 4) _____ Dosage: _____
- 5) _____ Dosage: _____

- 6) _____ Dosage: _____
- 7) _____ Dosage: _____
- 8) _____ Dosage: _____
- 9) _____ Dosage: _____
- 10) _____ Dosage: _____

Your Past Medical History

Please circle any applicable past or current illnesses and elaborate below:

Autoimmune Disease Cancer Diabetes Heart Disease Hepatitis/Liver Disease High Blood Pressure Infections
Kidney Disease Mental Illness Rheumatic Fever Seizures Stroke Thyroid Disease
Sexually Transmitted Infections Other

Surgeries (date): _____

Significant Trauma (car accidents, injuries, etc.) _____

Allergies (drugs, chemicals, environmental, foods) _____

Family Medical History

Please indicate family member and Mother's side (M) or Father's side (F)

Allergies	Asthma	Autoimmune Disease	Cancer
Diabetes	Heart Disease	High Blood Pressure	Kidney Disease
Seizures	Stroke	Arthritis	Other

Current Lifestyle

Current stress level (chemical, occupational, physical, psychological) _____

Weekly Exercise (Frequency and type) _____

Do you smoke? If so, how much and for how long? _____

Are you or have you ever been on a restricted diet? _____ What kind? _____

Vegetarian or Vegan? (please circle)

Do you avoid any specific foods? If so, why? _____

How much alcohol do you drink per week? _____

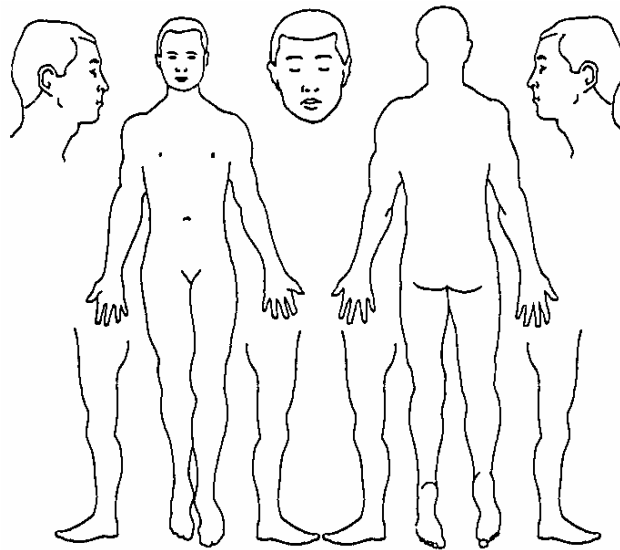
Please check any of the below symptoms if they are currently a problem OR are a recurring problem:

General:

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Weight gain/loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Strong thirst |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Sudden energy drop (what time of day)? |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Change in appetite | |

Musculoskeletal

Please Indicate any Painful Areas:



- Arthritis
- History of Injuries

- Osteoporosis
- Swelling

- Muscle Pain or weakness
- Areas of numbness/swelling

Skin, Hair and Nails:

- Rashes
- Hives
- Itching

- Eczema
- Pimples
- Dandruff

- Loss of hair
- Recent moles
- Change in hair or skin texture

Head, Eyes, Ears, Nose and Throat:

- Dizziness
- Concussions
- Migraines/headaches
- Eye pain
- Cataracts

- Blurry vision
- Earaches
- Ringing in ears
- Poor hearing
- Spots in front of eyes
- Sinus problems

- Nosebleeds
- Recurrent sore throats
- Grinding teeth
- Sores on lips or tongue
- Jaw clicks/pain

Cardiovascular:

- High blood pressure
- Chest pain
- Irregular heartbeat

- Fainting
- Cold hands or feet

- Swelling of hands/feet
- Blood clots

Respiratory

- Cough
- Difficulty or pain in breathing

- Coughing blood
- Production of phlegm (what colour)?

- Asthma

Gastrointestinal:

- Nausea/vomiting
- Indigestion/reflux
- Black stools
- Boating/Gas
- Blood/mucous in stools
- Constipation/Diarrhea
- Rectal pain
- Bad breath
- Hemorrhoids
- Abdominal pain or cramps

Genitourinary:

- Pain/urgency on urination
- Frequent urination
- Blood in urine
- Kidney stones
- Decrease flow rate
- Sexual dysfunction
- Sores on genitals
- Do you wake to urinate (how often)?

Obstetrics and Gynecology:

- ___ Age at first menses
- ___ Length of period
- ___ Length of cycle (days)
- Painful or heavy periods
- Irregular periods
- Vaginal discharge
- PMS
- ___ Number of pregnancies/births
- ___ Abortions/Miscarraiges
- Date of last PAP _____
- Self breast exams? _____
- Do you practice birth control?
What type and for how long?

Neuropsychological:

- Seizures
- Lack of coordination/balance
- Poor memory/focus
- Depression/Anxiety
- Quick temper / irritable
- Easily susceptible to stress
- Have you ever been treated
for emotional problems?
- Have you ever considered or
attempted suicide?

Any other comments or concerns?
