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:

	Yes	No	Date
Cancer	☐	☐	
Diabetes	☐	☐	
Stroke	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
Heart Disease	☐	☐	
Rheumatic Fever	☐	☐	
Thyroid Disease	☐	☐	
Seizures	☐	☐	

Other (Please describe:)

Family Medical History:

	Yes	No
Diabetes	☐	☐
Stroke	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Asthma	☐	☐
Allergies	☐	☐
Seizures	☐	☐
Cancer	☐	☐

Other (Please describe):

General Health

	Yes	No		Yes	No
Fevers	☐	☐	Weight loss	☐	☐
Sweat easily	☐	☐	Weight gain	☐	☐
Bleed or bruise easily	☐	☐	Strong thirst (hot or cold drinks)	☐	☐
Peculiar tastes or smells	☐	☐	Fatigue	☐	☐
Sudden energy drop	☐	☐	Night sweats	☐	☐
Poor sleeping	☐	☐	Cravings	☐	☐
Heavy limbs	☐	☐	Change in appetite	☐	☐

Skin and Hair

	Yes	No		Yes	No
Rashes	☐	☐	Hives	☐	☐
Dryness	☐	☐	Pimples	☐	☐
Itching	☐	☐	Recent moles	☐	☐
Dandruff	☐	☐	Hair loss	☐	☐
Eczema / Psoriasis	☐	☐	Change in hair or skin texture	☐	☐
Other (please describe)					

Head, Eyes, Ears, Nose Throat

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

Cardiovascular (heart and circulation)

	Yes	No		Yes	No
High blood pressure	☐	☐	Palpitations	☐	☐
Low blood pressure	☐	☐	Chest pain	☐	☐
Irregular heartbeat	☐	☐	Fainting	☐	☐
Cold hands/feet	☐	☐	Vein pain / swelling	☐	☐
Swelling of hands/feet	☐	☐		☐	☐
Other cardiovascular (please describe)					

Respiratory (lungs)

	Yes	No		Yes	No
Cough	☐	☐	Pneumonia	☐	☐
Bronchitis	☐	☐	Asthma	☐	☐
Coughing blood	☐	☐	Pain with deep breath	☐	☐
Phlegm	☐	☐			
Other respiratory (please describe)					

Gastrointestinal (stomach and intestines)

	Yes	No		Yes	No
Nausea	☐	☐	Black stools	☐	☐
Vomiting	☐	☐	Diarrhea	☐	☐
Bad breath	☐	☐	Hemorrhoids	☐	☐
Belching	☐	☐	Blood in stools	☐	☐
Indigestion	☐	☐	Rectal pain	☐	☐
Abdominal pain/cramps	☐	☐	Chronic laxative use	☐	☐
Constipation	☐	☐			
Other gastrointestinal (please describe)					

Genito-urinary

	Yes	No		Yes	No
Painful urination	☐	☐	Night urination	☐	☐
Urgency to urinate	☐	☐	Blood in urine	☐	☐
Frequent urination	☐	☐	Kidney stones	☐	☐
Unable to hold urine	☐	☐	Impotence	☐	☐
Decrease in flow	☐	☐	Genital sores	☐	☐
Other genital/urinary (please describe)					

Musculoskeletal (bone, joint and muscle)

	Yes	No		Yes	No
Neck pain	☐	☐	Knee	☐	☐
Back pain	☐	☐	Foot/ankle	☐	☐
Hand/wrist	☐	☐	Hip	☐	☐
Muscle	☐	☐	Muscle weakness	☐	☐
Shoulder	☐	☐	Osteoporosis	☐	☐
Other musculoskeletal (please describe)					

Neuropsychological

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

Reproductive and Gynecological

	Yes	No		Yes	No
Number of pregnancies			Irregular periods	☐	☐
Abortions			Painful periods	☐	☐
Live births			Clots	☐	☐
Premature births			Vaginal discharge	☐	☐
Miscarriages			Vaginal sores	☐	☐
Age of first menses			Breast lumps	☐	☐
Last menstrual period			Irregular paps	☐	☐
Length of cycle					
Duration of menses					
Last pap					
Changes in psyche/body prior to menstruation:				☐	☐
If yes, please describe:					