Health History Questionnaire

Please help us provide a complete evaluation by filling out this questionnaire carefully. All of your answers will be held confidentially. If there is anything you wish to bring to our attention that is not addressed on this form, please note it in the "comments" section. Thank you.

General Information

Name	Home phone
Address	Work phone
City, State, Zip	Birthdate Birthplace
Work occupation	Email address
Who is your doctor?	Approx. date of last exam
Are you now under a dr's care?	For what reason?
Are involved with other healers?	Describe them

Focus

What is your chief concern?
List any other current symptoms or problems?
What are your goals for health/life?
What is flourishing in your life?
What are 3 factors that seem most important to your daily health?

Review of Systems/symptoms Check any problems you have had in the last 3 months.

	Weight loss or gain		Blackouts		Shortness of breath		Burning urination
	Fatigue		Earaches		Coughing blood		Bladder infection
	Confusion		Vision problems		Heart palpitations		Kidney infection
	Nervousness		Nasal congestion		Chest pain		Bedwetting
	Muscle tension		Sinus pressure		Breast lumps/pain		Blood in urine
	Muscle cramps		Nosebleeds		Poor endurance		Back pain
	Cold hands or feet		Mucous problems		Gas		Leg swelling
	Itching		Sores in mouth		Abdominal pain		Bone/joint pain
	Skin rashes		Tongue problems		Difficult digestion		Arm problems
	Skin boils		Bad breath		Constipation		Shoulder problems
	Headaches		Sore throat		Diarrhea		Leg problems
	Fevers		Teeth/gum problems		Irregular bowels		Joint swelling
	Nightmares		Neck pain		Bloody/black stools		Bruise easily
	Dizziness		Cough		Hemorrhoids		Change in sex drive
	Ringing in ears		Difficulty breathing		Urinary problems		Aging rapidly

Personal Medical History

Do you have allergies? If so, to what?
Do you take any prescribed medications? Please list
Do you take any over the counter medications? Please list
Do you take any vitamins, minerals, herbs or supplements? Please list
Have you had any surgeries or hospitalizations? Please list by type and year
Have you had any injuries or accidents? Please list by type any year

Check any of the following that you have ever had. Write the approximate year.

	Pneumonia		Skin boils		Polio		Mental breakdown
	Tuberculosis		Kidney stones		Syphilis		Jaundice
	Hepatitis		Drug reaction		Blood transfusion		Kidney infection
	Asthma		Psoriasis		Migraine headache		Parasites
	Diabetes		Hives		Ulcer		Rheumatic fever
	Hypoglycemia		High blood pressure		Anemia		Measles
	Epilepsy		Low blood pressure		Arthritis		German measles
	Eczema		Heart disease		Obesity		Mumps
	Chicken pox		Heart attack		Whooping cough		Diphtheria
	Colitis		Cancer		Gonorrhea		Chronic disease

Family History

RELATIONSHIP	NAME	BIRTHDATE	HEALTH
Spouse/Partner			
Mother			
Father			
Sister(s)			
Brother(s)			
Child(ren)			

Do any of the following run in the family?

	Diabetes		Asthma		Mental illness
	High blood pressure		Gout		Thyroid problems
	Heart disease		Cancer		Obesity
	Tuberculosis		Epilepsy		Arthritis

Diet & Activities

Do you have a good appetite? Good eating habits?
How do you feel about the foods you eat?
How often do you eat restaurant food?
Is there a food flavor that you crave? What?

How many servings a day do you eat of the following foods?

Fruits	Grains	Dairy
Vegetables	Nuts, beans, seeds	Meats

Write the average # of times you consume the following each week

Beef	Chicken	Fish	Citrus
Fried food	Sugar	Coffee, tea, soda	Nicotine
Wine	Beer	Liquor	Recreational drugs

Do you have a garden? Vegetable? Flower?
Do you do any regular exercise? What kind? How often?
Do you enjoy exercise?
Do you sweat easily?

General Questions

Are you able to express all your emotions & feelings?
Are any of the following dominant feelings for you? Anger Sadness Fear Worry Excessive joy Depression Other(name)
What makes you nervous?
Is there stress in your life? How much? What is the source?
Were you born at home or in a hospital? Were you breast or bottle fed?
Do you sleep well? What hours?
Do you remember your dreams? Are they helpful?
Are you happy with your general energy level? Is there a low point in your day? When?
Do you have a favorite time of day?
Are there climates you especially don't like? Why?
What is your favorite color? Favorite season?
Highest level of school completed? Other life training?
Any military service? What & when?
With whom do you live? Do you have pets?
What are your hobbies/pleasures?
What are your indulgences?
Have you ever abstained from or quit anything? What? Why? How long?
How do you feel about yourself?
How do you feel about your life?
Is there anything else we should know to understand you? Date: _____ _____ Patient Signature