

Health History Intake

Date _____

Patient Information	Contact Information
<p>Last Name: _____</p> <p>First Name: _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birth Date _____ Gender _____</p> <p><input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married</p> <p>Occupation _____</p> <p>Credit Card # _____</p> <p>Exp Date _____ CNN _____ Zip Code _____</p> <p>Name on Card _____</p>	<p>Home phone _____</p> <p>Cell phone _____</p> <p>Email _____</p> <p>Emergency contact:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Cell phone _____</p> <p>How did you hear about us? _____</p> <p>Primary physician _____</p> <p>Physician phone _____</p>
<p>What is (are) your main complaint(s)?</p> <p>1 _____</p> <p>How long have you had? _____</p> <p>Is there a diagnosis? _____</p> <p>Due to an injury/illness (specify)? _____</p> <p>2 _____</p> <p>How long have you had? _____</p> <p>Is there a diagnosis? _____</p> <p>Due to an injury/illness (specify)? _____</p> <p>3 _____</p> <p>How long have you had? _____</p> <p>Is there a diagnosis? _____</p> <p>Due to an injury/illness (specify)? _____</p>	<p>List medications/purpose & food supplements:</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>List major hospitalizations/surgeries and year/age:</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>Family Medical History.</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Seizures <input type="checkbox"/> Mental health: _____</p> <p>Other: _____</p>

LIFE STYLE	SYMPTOMS
<p>General Health Status:</p> <p>Appetite: <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excessive</p> <p>Sleep: <input type="checkbox"/> Good <input type="checkbox"/> Difficulty falling <input type="checkbox"/> Wake >than 1x <input type="checkbox"/> Excessive dreaming. Wake rested: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Energy level, rate from 1-10, (10=excessive) _____</p> <p>Energy dips? <input type="checkbox"/> Yes <input type="checkbox"/> No Time of day/night? _____</p> <p>Areas of Stress: <input type="checkbox"/> None <input type="checkbox"/> Work <input type="checkbox"/> Family <input type="checkbox"/> School <input type="checkbox"/> Other _____</p> <p>Diet: Do you follow a specific diet? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what type: _____</p> <p>Typical Breakfast _____</p> <p>Typical Lunch _____</p> <p>Typical Dinner _____</p> <p>Typical Snacks _____</p> <p># of glasses water/day _____</p> <p># of cups of caffeine/day _____</p> <p>Smoke Tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No How many/day? _____</p> <p>Drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How many/week? _____</p> <p>Recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____</p> <p>Exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____</p> <p>General Medical History.</p> <p><input type="checkbox"/> Fevers <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Always warm</p> <p><input type="checkbox"/> Chills <input type="checkbox"/> Always cold <input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/> Weight gain or loss <input type="checkbox"/> Change in appetite <input type="checkbox"/> Cravings</p> <p><input type="checkbox"/> Thirst for cold drinks <input type="checkbox"/> Thirst for warm drinks</p> <p><input type="checkbox"/> No desire to drink <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Heart disease <input type="checkbox"/> Herpes <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Cancer, where? _____</p> <p>Other: _____</p>	<p>Check symptoms that have occurred in the last year:</p> <p>Muscles/Joints/Bones</p> <p><input type="checkbox"/> Frequent muscle cramps or spasms</p> <p><input type="checkbox"/> Swollen joints</p> <p><i>Pain, weakness, and/or numbness in:</i></p> <p><input type="checkbox"/> Jaw (TMJ) <input type="checkbox"/> Headache/Migraine</p> <p><input type="checkbox"/> Shoulders <input type="checkbox"/> Neck <input type="checkbox"/> Headache/Migraine</p> <p><input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Wrist <input type="checkbox"/> Fingers</p> <p><input type="checkbox"/> Hips <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> Upper Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back</p> <p><input type="checkbox"/> Legs <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Feet <input type="checkbox"/> Ankle <input type="checkbox"/> Toes</p> <p><input type="checkbox"/> Other _____</p> <p>Eyes/Ears/Nose/Throat/Respiratory</p> <p><input type="checkbox"/> Blurred or failing vision or floaters</p> <p><input type="checkbox"/> Dry, irritated or watery eyes</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Ringing in the ears, tinnitus</p> <p><input type="checkbox"/> Earaches</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Persistent cough, sore throat</p> <p><input type="checkbox"/> Gum trouble</p> <p><input type="checkbox"/> Asthma/wheezing</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Frequent colds</p> <p><input type="checkbox"/> Allergies, specify _____</p> <p>Skin</p> <p><input type="checkbox"/> Boils, acne <input type="checkbox"/> Warts</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Itching/rash/hives</p> <p><input type="checkbox"/> Sensitive skin</p> <p><input type="checkbox"/> Sores that won't heal</p> <p><input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other _____</p>

SYMPTOMS	SYMPTOMS
<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> High or <input type="checkbox"/> low blood pressure <input type="checkbox"/> Heart Pain <input type="checkbox"/> Previous heart attack <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid/irregular heart beat <input type="checkbox"/> Swelling of ankles <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Acid reflux/Gerd <input type="checkbox"/> Belching <input type="checkbox"/> Indigestion <input type="checkbox"/> Gas <input type="checkbox"/> Abdominal distention or bloating <input type="checkbox"/> Nausea and/or vomiting <input type="checkbox"/> Pain <input type="checkbox"/> Upper abdomen <input type="checkbox"/> Lower Abdomen <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Polyps <input type="checkbox"/> Cancer <input type="checkbox"/> Colitis <input type="checkbox"/> Crohn's <input type="checkbox"/> IBS <input type="checkbox"/> Other <p>_____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea/Loose stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Gall bladder disorder, describe_____ <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of balance <input type="checkbox"/> Seizure <input type="checkbox"/> Concussion <input type="checkbox"/> Numbness, loss of feeling <input type="checkbox"/> Nerve pain <p>Psychological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Manic Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> Bad temper, easily agitated <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Nervous condition or easily susceptible to stress <p>Have you considered/attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you been treated for emotional problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Genito/Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent or night time urination <input type="checkbox"/> Inability to control urine, dribbling, weak stream <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urinary tract infections <input type="checkbox"/> Blood/pus in urine <input type="checkbox"/> Kidney infection/stones <input type="checkbox"/> Kidney disease <input type="checkbox"/> Venereal disease <p>Reproductive and Gynecological (women)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Scanty menstrual flow <input type="checkbox"/> Excessive menstrual flow <input type="checkbox"/> Clots in menses <input type="checkbox"/> Moderate to Extreme menstrual pain <input type="checkbox"/> Irregular cycle <input type="checkbox"/> PMS <input type="checkbox"/> Hot flashes/night sweats <input type="checkbox"/> Reduced libido <p>Age of first menses _____ # of days of bleeding _____</p> <p># of days between menses _____</p> <p># of Pregnancies _____ # of Births: _____</p> <p># of Miscarriages _____</p> <p>Any possibility that you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reproductive (men)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Penis discharge <input type="checkbox"/> Prostate disorder <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Reduced libido <p>Tell us about anything you would like to discuss.</p> <p>_____</p> <p>_____</p> <p>_____</p>

My signature confirms that the information on this form is correct to the best of my knowledge.

Signature _____ Date _____