

## HEALTH QUESTIONNAIRE

Please answer the questions carefully. *All information will be held in the strictest confidence.*  
If you have any questions, please ask. Feel free to add details not covered by the questions.

Name:

Mailing Address:

City, State, Zip:

Home Phone:

Work Phone:

Cell Phone:

Fax:

email address:

Birth date:

Height & Weight:

Emergency Contact:  
(Name & Number)

Referred by:

MAJOR COMPLAINTS:

What diagnosis, if any, have you been given?

Diseases (check all that apply & any treatments)

- |                                                                                   |                                                        |                                              |
|-----------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cancer                                                   | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Heart Disease                                            | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease                                          | <input type="checkbox"/> Seizures                      |                                              |
| <input type="checkbox"/> Reactions to childhood, tourist or military vaccinations |                                                        |                                              |
| <input type="checkbox"/> Other (please specify)                                   |                                                        |                                              |

Surgeries (include year):

Significant Trauma: (Describe accidents, falls, etc., with dates, treatment, results)

Allergies:

Family Medical History: (Please explain and identify family member in relation to you)

- |                                        |                                   |                                              |
|----------------------------------------|-----------------------------------|----------------------------------------------|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies           |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma   | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other               |

Medicines taken within the last two months (including vitamins, drugs, herbs, etc.)

How many cigarettes do you smoke a day?

How much coffee, tea or cola do you drink a day?

How much alcohol do you drink during a typical week?

PLEASE EXPLAIN if you have had any of the following within the last 3 months:

**GENERAL:**

- |                                                          |                                                         |                                        |
|----------------------------------------------------------|---------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Poor Appetite                   | <input type="checkbox"/> Fevers                         | <input type="checkbox"/> Fatigue       |
| <input type="checkbox"/> Strong Thirst (cold/hot drinks) | <input type="checkbox"/> Poor Sleeping/Trouble Sleeping | <input type="checkbox"/> Night Sweats  |
| <input type="checkbox"/> Sweating Easily                 | <input type="checkbox"/> Chills                         | <input type="checkbox"/> Food Cravings |
| <input type="checkbox"/> Localized Weakness              | <input type="checkbox"/> Change in Appetite             | <input type="checkbox"/> Tremors       |
| <input type="checkbox"/> Bleed or Bruise Easily          | <input type="checkbox"/> Poor Balance                   | <input type="checkbox"/> Weight Gain   |
| <input type="checkbox"/> Peculiar Tastes or Smells       | <input type="checkbox"/> Weight Loss                    | <input type="checkbox"/> Energy Drop*  |
| <input type="checkbox"/> Cravings (all that apply):      |                                                         | *Time of day?                          |
| Sugar    Salt    Sour    Spicy    Fats                   |                                                         |                                        |

**SKIN AND HAIR:**

- |                                                         |                                       |                                       |
|---------------------------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes                         | <input type="checkbox"/> Ulcerations  | <input type="checkbox"/> Hives        |
| <input type="checkbox"/> Itches                         | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Pimples      |
| <input type="checkbox"/> Dandruff                       | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Change in Hair or Skin Texture |                                       |                                       |
- Any other hair or skin problems?

**HEAD, EYES, EARS, NOSE AND THROAT:**

- |                                                      |                                          |                                                  |
|------------------------------------------------------|------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Concussion/s    | <input type="checkbox"/> Migraines               |
| <input type="checkbox"/> Glasses                     | <input type="checkbox"/> Eye Strain      | <input type="checkbox"/> Eye Pain                |
| <input type="checkbox"/> Poor Vision                 | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness         |
| <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Blurry Vision   | <input type="checkbox"/> Ear Aches               |
| <input type="checkbox"/> Ringing in Ears             | <input type="checkbox"/> Poor Hearing    | <input type="checkbox"/> Spots in Front of Eyes  |
| <input type="checkbox"/> Sinus Problems              | <input type="checkbox"/> Nose Bleeds     | <input type="checkbox"/> Recurrent Sore Throats  |
| <input type="checkbox"/> Grinding Teeth              | <input type="checkbox"/> Facial Pain     | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Teeth Problems              | <input type="checkbox"/> Clicking Jaw    |                                                  |
| <input type="checkbox"/> Headaches - Where and When? |                                          |                                                  |

Any other head or neck problems?

**CARDIOVASCULAR:**

- |                                              |                                             |                                     |
|----------------------------------------------|---------------------------------------------|-------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
|----------------------------------------------|---------------------------------------------|-------------------------------------|

- |                                              |                                            |                                                  |
|----------------------------------------------|--------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Fainting                |
| <input type="checkbox"/> Cold Hand or Feet   | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Swelling in Feet        |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Phlebitis         | <input type="checkbox"/> Difficulty in Breathing |

Any other heart or circulatory problems?

**RESPIRATORY:**

- |                                                             |                                            |                                                 |
|-------------------------------------------------------------|--------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Cough                              | <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Bronchitis                         | <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Pain with Deep Breaths |
| <input type="checkbox"/> Difficulty Breathing if Lying Down |                                            |                                                 |
| <input type="checkbox"/> Production of Phlegm - What color? |                                            |                                                 |

Any other lung problems?

**GASTROINTESTINAL:**

- |                                                   |                                          |                                               |
|---------------------------------------------------|------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Nausea                   | <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Gas             | <input type="checkbox"/> Belching             |
| <input type="checkbox"/> Black Stools             | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion          |
| <input type="checkbox"/> Bad Breath               | <input type="checkbox"/> Rectal Pain     | <input type="checkbox"/> Hemorrhoids          |
| <input type="checkbox"/> Abdominal Pain or Cramps |                                          | <input type="checkbox"/> Chronic Laxative Use |

Any other problems with your stomach or intestines?

**GENITO-URINARY:**

- |                                                 |                                               |                                            |
|-------------------------------------------------|-----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Pain on Urination      | <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Blood in Urine    |
| <input type="checkbox"/> Urgency to Urinate     | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Kidney Stones        | <input type="checkbox"/> Impotency         |

Waking Up at Night to Urinate - How frequently?

Any particular color to your urine?

Any other problems with your genital or urinary system?

**REPRODUCTIVE AND GYNECOLOGIC:**

- |                                                                                                                   |                                                                     |                                                   |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------|
| Pregnancies: _____                                                                                                | Date of Last Menses: _____                                          | <input type="checkbox"/> Irregular Periods        |
| Births: _____                                                                                                     | Duration of Menses: _____                                           | <input type="checkbox"/> No Periods               |
| Miscarriages: _____                                                                                               | Days between: _____                                                 | <input type="checkbox"/> Breast Lumps/Pain        |
| Abortions: _____                                                                                                  | Flow: <input type="checkbox"/> Heavy <input type="checkbox"/> Light | <input type="checkbox"/> Chronic Yeast Infections |
| Date of Last PAP: _____                                                                                           |                                                                     |                                                   |
| Clots: <input type="checkbox"/> Dark <input type="checkbox"/> Red <input type="checkbox"/> Menopause - Age: _____ |                                                                     |                                                   |

Birth Control (What type? For How Long?):  
Pain throughout Menstrual Cycle (Check all that apply):  
 Beginning  Ending  Ovulation

Vaginal Discharges/Leukorrhea (please describe):

PMS Changes in Body & psyche (When? Symptoms?):

Other Conditions:

**MUSCULOSKELETAL:**

- |                                          |                                          |                                           |
|------------------------------------------|------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Muscle Pains    | <input type="checkbox"/> Knee Pain        |
| <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot/Ankle Pains |
| <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Shoulder Pain   | <input type="checkbox"/> Hip Pain         |

Any other joint or bone problems?

**NEUROPSYCHOLOGICAL:**

- |                                            |                                                   |                                          |
|--------------------------------------------|---------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination     | <input type="checkbox"/> Poor Memory     |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Depression               | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> Bad Temper        | <input type="checkbox"/> Low Tolerance for Stress |                                          |

Have you ever been treated for emotional problems?