

CLIENT HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

TREATMENT: What type of treatment are you looking for? <input type="checkbox"/> I am looking for the most minimal amount of care to "patch up the symptoms" of my problem. <input type="checkbox"/> I am looking to resolve my symptoms and then go on to "fix the cause" of my problem. <input type="checkbox"/> I am looking to take care of my problem and then go on to "achieve optimal health and wellness."		Original Date: Dates Revised:
Name (<i>Last, First, M.I.</i>): _____		<input type="checkbox"/> M <input type="checkbox"/> F DOB: _____
Previous or referring doctor: _____		Date of last physical exam: _____
PERSONAL HEALTH HISTORY		
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis <input type="checkbox"/> Influenza	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Chickenpox <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
COMPLAINT/PROBLEM: (In relation to your <u>primary</u> complaint): _____		
When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: <input type="checkbox"/> Y <input type="checkbox"/> N If yes, whom? _____ Treatment(s): _____ Have you had any intolerance or reactions to treatments? <input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____ If this is a recurrence, when was the first time you noticed this problem? _____ How did it originally occur? _____ Has it become worse recently? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Gradually worse How frequent is the condition? <input type="checkbox"/> Constant <input type="checkbox"/> Daily <input type="checkbox"/> Intermittent <input type="checkbox"/> Night only How long does it last? <input type="checkbox"/> All day <input type="checkbox"/> Few hours <input type="checkbox"/> Minutes Is this condition interfering with your: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily routine <input type="checkbox"/> Recreation <input type="checkbox"/> Other : _____ How long has it been since you really felt good? <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> >10 years Describe the pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Stabbing <input type="checkbox"/> Other: _____ What makes the problem worse? <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying <input type="checkbox"/> Bending <input type="checkbox"/> Lifting <input type="checkbox"/> Twisting <input type="checkbox"/> Other: _____ Is there anything that you can do to relieve the problem? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe: _____ If no, what have you tried to do that has not helped? _____ What do you believe is wrong with you? _____ Are there any other conditions or symptoms that may be related to your major symptom? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, what? _____ Have you been in an auto accident? <input type="checkbox"/> Past year <input type="checkbox"/> Past 5 years <input type="checkbox"/> Over 5 years <input type="checkbox"/> Never Describe: _____		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, include nutritional supplements

Name the Drug/Supplement	Strength	Frequency Taken

Allergies to Food/Medications/Environment

Name the Allergen	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Are you willing to follow a treatment program designed to help you return to health for at least 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you willing to take nutritional supplements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you willing to make dietary changes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you willing to start a moderate exercise program if necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low		
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used: _____		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

**CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU, PAST AND PRESENT.
PLEASE ADD YOUR COMMENTS TO CLARIFY THE CONDITION.**

<p>Musculo-Skeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Joint stiffness/swelling <input type="checkbox"/> Spasms/cramps <input type="checkbox"/> Broken/fractured bones <input type="checkbox"/> Strains/sprains <input type="checkbox"/> Back, hip pain <input type="checkbox"/> Shoulder, neck, arm, hand pain <input type="checkbox"/> Leg, foot pain <input type="checkbox"/> Chest, ribs, abdominal pain <input type="checkbox"/> Problems walking <input type="checkbox"/> Jaw pain/TMJ <input type="checkbox"/> Tendonitis <input type="checkbox"/> Bursitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Bone or joint disease <input type="checkbox"/> Other: _____ <p>Circulatory and Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Fainting <input type="checkbox"/> Cold feet or hands <input type="checkbox"/> Cold sweats <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Pressure sores <input type="checkbox"/> Varicose veins <input type="checkbox"/> Blood clots <input type="checkbox"/> Stroke <input type="checkbox"/> Heart condition <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus problems <input type="checkbox"/> Asthma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Lymphedema <input type="checkbox"/> Other: _____ 	<p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Allergies <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Warts <input type="checkbox"/> Moles <input type="checkbox"/> Acne <input type="checkbox"/> Cosmetic surgery <input type="checkbox"/> Other: _____ <p>Digestive</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervous stomach <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> Intestinal gas/bloating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Colitis <input type="checkbox"/> Adaptive aids <input type="checkbox"/> Other: _____ <p>Nervous System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Twitching of face <input type="checkbox"/> Fatigue <input type="checkbox"/> Chronic pain <input type="checkbox"/> Sleep disorders <input type="checkbox"/> Ulcers <input type="checkbox"/> Paralysis <input type="checkbox"/> Herpes/shingles <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Epilepsy <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Other: _____ 	<p>Reproductive System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnancy: <ul style="list-style-type: none"> <input type="checkbox"/> Current <input type="checkbox"/> Previous <input type="checkbox"/> PMS <input type="checkbox"/> Menopause <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Endometriosis <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Fertility concerns <input type="checkbox"/> Prostrate problems <p>Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Drug use _____ <input type="checkbox"/> Alcohol use _____ <input type="checkbox"/> Nicotine use _____ <input type="checkbox"/> Caffeine use _____ <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Visually impaired <input type="checkbox"/> Burning upon urination <input type="checkbox"/> Bladder infection <input type="checkbox"/> Eating disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Post/Polio Syndrome <input type="checkbox"/> Cancer <input type="checkbox"/> Infectious disease (please list) _____ <input type="checkbox"/> Other congenital or acquired disabilities (please list) _____ <input type="checkbox"/> Surgeries _____ <input type="checkbox"/> Other: _____ <p>For clients who need mobility assistance, please give your height: _____ weight: _____</p>
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I have stated all conditions that I am aware of; this information is true and accurate to the best of my knowledge. I will inform the health care provider of any changes in my status.

Client's Name (print): _____

Client's/Legal Guardian's Signature: _____

Witness: _____ Date: _____