Health History Intake Form

Please complete this health history questionnaire. All information will be kept strictly confidential unless you have specifically agreed to allow me to use your case anonymously as part of my clinical record.

Name: _____

Age: _____ Weight: _____ Height: _____

Reason for visit/ when did this begin:

_____

Has it recently changed or become worse? _____

Primary health goal: _____

Secondary health goal: _____

Past Medical History

Where were you born? _____

Where are you in the birth order of your family (if known)?_____

Were there any complications when you were born? _____

Have you ever been diagnosed with any of the conditions listed here? If so, who made the diagnosis? When? Describe any treatments.

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Hepatitis ☐ Thyroid disease ☐ Seizures ☐ Other?

Surgeries (including cosmetic & dental)? Provide year for each. _____

Hospitalizations? Provide year and reason for each. _____

Allergic to drugs/chemicals/foods? How were they diagnosed and/or treated? _____

Major trauma (concussion, accidents, physical or emotional trauma)? Provide year for each. _____

Are you currently receiving care from any other health professional?_____
(Name/ type)_____
What condition(s)?_____

List of all medications you have used in the past 6 months. Be sure to include prescription drugs, over-the-counter medications you have purchased yourself, herbs, vitamins and supplements. Indicate the reason you took each, who recommended them, dosage and how long you used each one.

_____
_____

Family Medical History

Has anyone in your immediate, biological family (parents, grandparents, siblings or children) ever been diagnosed with any of these conditions?

☐ Cancer/Type _____ ☐ Diabetes ☐ Heart disease ☐ High Blood Pressure

☐ Thyroid Disease ☐ Mental Health Issues ☐ Seizures ☐ Alcoholism ☐ Hepatitis

☐ Other (please list) _____

Lifestyle

Whom do you live with? _____ Relationship status? _____

Occupation: _____ How long have you had this occupation? _____

Describe your job/work. _____

How many hours per day? _____ Start & finish time? _____ Hours worked per week? _____

How many days off per week? _____

How many days vacation per year? _____

What is your work setting? _____

Does your work involve travel? _____ If so, please describe: _____

Commute time to and from work: _____

What are physical demands of your work (standing, sitting, computer use, etc.) _____

_____

Do you enjoy your work? _____

Exercise type and frequency:

How long have you been involved in this type of exercise? _____

Sleep Habits

	Hours of sleep per night		Insomnia
	Usual bedtime		Trouble falling asleep
	Usual time you wake up		Trouble staying asleep
	Different sleep schedule on weekends/days off		Dreams
	Work at night		Use sleep medications. How often?
	Disturbed sleep for any reason		Sleep apnea

General Habits

☐ Cigarettes: Do you currently smoke? How many cigarettes per day? If you smoked in the past, how many years did you smoke? When did you quit? _____

☐ Coffee: How many cups per day? _____

☐ Tea: What kind? _____ How much per day? _____

☐ Soda: What kind?_____ How many sodas per day? _____

☐ Alcohol: How much alcohol do you drink each day? _____Each week? _____ Each month? _____

What kind of alcoholic beverages do you enjoy? _____

☐ Has your drinking ever caused problems in your life such as family issues, job loss, legal problems?

☐ Recreational drugs: Are you currently using any kind of recreational drug? _____
What kind and how often? _____ Have you used them in the past? _____

☐ Have you ever been treated for drug or alcohol addiction? _____
Are you currently in any type of recovery program? _____

☐ Do you take prescription medications for depression, anxiety or other psychological symptoms?

☐ Do you crave sugar? What kind of sweets do you enjoy? _____

☐ Do you crave salt? What kind of salty foods do you enjoy? _____

☐ Television: How much TV do you watch each day?_____ Each week? _____

☐ Computer: What amount of time do you spend on a computer each day? _____ Each week? _____

☐ Video games: What amount of time do you spend playing video games each day? _____Each week? ____

Diet

On a separate piece of paper, please provide a five-day food diary noting everything you eat or drink along with a rough estimate of the quantity of food eaten and time of day.

How long has this been your normal diet? _____ If it has changed recently, what was it before?
_____

How soon after you wake up do you eat or drink? _____

How long have been at your current weight? _____

Any significant weight gain/loss in the past five years? _____

Have you ever been treated for an eating disorder? _____

☐ Good appetite? ☐ Poor appetite?

Do you crave specific foods? _____ Which ones? _____

How much water do you drink each day? _____ Do you keep track of your water intake? _____

What is your primary source of drinking water? _____

Health History

Please check any health issue that you have had in the past or are currently experiencing, along with a description of any treatments used for each symptom checked.

Skin

☐	Rashes (where?)	☐	Acne
☐	Ulcerations	☐	Excessively oily skin
☐	Hives	☐	Excessively dry skin
☐	Itching	☐	Hair loss
☐	Eczema	☐	Dandruff
☐	Psoriasis	☐	Other

Treatments:_____

EENT

☐	Glasses or contacts	☐	Frequent ear infections
☐	Glaucoma	☐	Hearing loss
☐	Cataracts	☐	Hay fever
☐	Night blindness	☐	Migraine or other chronic headaches
☐	Hearing aids	☐	TMJ
☐	Ringing in ears	☐	Chronic dental problems (cavity/root canal/etc)
☐	Sinus problems (chronic congestion/infections)	☐	Mouth ulcers/Oral herpes
☐	Excessive/insufficient saliva	☐	Gum disease

Treatments:_____

Cardiovascular

☐	High or low blood pressure	☐	Arrhythmia (irregular heart rate)
☐	Elevated cholesterol or triglyceride levels	☐	Swelling in hands or feet
☐	Poor circulation	☐	Chest pain
☐	Heart disease	☐	Numbness (where?)
☐	Heart palpitations	☐	Pacemaker

Treatments:_____

Respiratory

☐	Chronic cough	☐	Bronchitis (frequency/treatment)
☐	Frequent colds/respiratory infections	☐	Pneumonia (frequency/treatment)
☐	Asthma (onset/treatment)	☐	Number of colds per year
☐	Difficulty breathing	☐	Number of sinus infections per year
☐	Breathless with exertion	☐	Lung disease (describe)
☐	Emphysema	☐	

Treatments:_____

Urinary Tract

☐	Bladder infections (current or in the past)	☐	Wake up in the night to urinate
☐	Cystitis	☐	Blood in urine
☐	Kidney infections	☐	Kidney stones
☐	Incontinence	☐	Family history of kidney disease
☐	Frequent urination	☐	Other

Treatments: _____

Gastrointestinal

☐	Nausea	☐	Gastric reflux
☐	Gas	☐	Heartburn
☐	Belching	☐	Irritable Bowel Syndrome
☐	Indigestion	☐	Diverticulitis
☐	Bad breath (halitosis)	☐	Crone's disease
☐	Bloating after meals	☐	Gastric bypass or similar procedures
☐	Chronic or frequent constipation or diarrhea	☐	Hemorrhoids
☐	Number of bowel movements per day	☐	Blood in stool
☐	Undigested food in stool	☐	Pain or discomfort with bowel movements

Treatments:_____

Men: Reproductive Health

☐	Prostate inflammation or swelling	☐	Pain or difficulty urinating
☐	Prostate cancer	☐	Venereal disease
☐	Infertility issues	☐	Frequent marijuana user
☐	Benign prostate hypertrophy	☐	Impotence or erectile problems

If you are over 50 years of age: Do you have annual PSA screening? _____ Last screening: _____

Treatments:_____

Women: General Reproductive Health

☐	Age of first menses	☐	Breakthrough bleeding
☐	Cycle of menstrual period/days	☐	Fibroids/type?
☐	Length of period	☐	Ovarian cysts/PCOS
	PMS symptoms (please check all that apply)	☐	Pelvic inflammatory disease
☐	Edema (swelling of hands or feet)	☐	Sexually transmitted disease/type?
☐	Food cravings	☐	Herpes
☐	Mood swings	☐	Vaginal warts
☐	Insomnia	☐	Cervical dysplasia
☐	Headaches	☐	Irregular PAP test/when?
☐	Cramping	☐	Uterine cancer
☐	Bloating	☐	Ovarian cancer
☐	Breast tenderness	☐	Breast lumps/cysts
☐	Heavy menstrual flow/Blood clots	☐	Breast augmentation
☐	Irregular menstrual cycle	☐	Breast cancer
☐	Skipped periods	☐	Breast pain
☐	Pain at ovulation (mid cycle pain)	☐	Other

Treatments:_____

Pregnancy

☐	Have you ever been pregnant?	☐	Currently using birth control
☐	Number of live births	☐	Type of birth control used:
☐	Number of miscarriages	☐	Are you or could you be pregnant now?
☐	Number of abortions	☐	Infertility issues
☐	Health issues during pregnancy?	☐	Other

Date of last PAP:_____ Date of last mammogram:_____

Treatments:_____

Peri-menopausal/Menopausal symptoms (please check all that apply)

☐	Are you currently having regular menstrual periods?	☐	Headaches
☐	Hot flashes	☐	Heavy menstrual bleeding/flooding
☐	Night sweats	☐	Incontinence/frequent urination
☐	Insomnia/sleep problems	☐	Memory problems/Poor concentration
☐	Weight gain	☐	Mood swings
☐	Lack of libido	☐	Depression
☐	Vaginal dryness	☐	Fatigue
☐	Currently using hormone replacement therapy	☐	Currently using bio-identical hormones

Date of last menstrual period:_____

Treatments:_____

Musculoskeletal

☐	Chronic neck or back pain	☐	Back surgery
☐	Neck or shoulder tightness	☐	Osteoarthritis
☐	Low back pain	☐	Rheumatoid arthritis
☐	Osteoporosis	☐	Frequent sprains/torn ligaments
☐	Osteopenia	☐	Other

Treatments:_____

Neuropsychological

☐	Depression	☐	Frequently feel overwhelmed
☐	Anxiety attacks	☐	Experiencing high stress levels
☐	Poor memory	☐	Ever considered or attempted suicide
☐	Difficulty concentrating	☐	Treated for depression or other psychological issues
☐	Lose your temper easily	☐	Treated for alcohol or drug addiction

Treatments: _____

How would you rate your stress level right now? _____

_____

What feeling do you experience most strongly/ frequently in your life? _____

Is there anything else affecting your health right now that you would like me to know about?

_____

_____