## Health History

Please help us provide you with a complete and accurate evaluation by taking the time to fill out this questionnaire carefully. All information gathered is confidential except as required or allowed by law. You will be asked for written authorization for release of any information.

Name_____ Date_____
Address_____ City_____ Postal Code_____
Home Phone_____ Work Phone_____ ext_____
Cell Phone_____ E-mail_____
Date of Birth_____ Age_____ Weight_____ Height_____
Family Physician_____ Address_____ Phone_____
Occupation_____
How did you hear about this clinic/Who referred you?_____

What is your primary complaint?_____
_____

How does this condition affect you?_____
_____

What have you tried for relief ? (other therapies, medications, heat/cold)_____
_____

Any other conditions or areas of concern?_____

**Family Health History:**

| | | |
|---|---|---|
| ☐ Allergies | ☐ Epilepsy/seizures | ☐ Mental illness |
| ☐ Cancer | ☐ Heart disease | ☐ Stroke |
| ☐ Diabetes | ☐ High blood pressure | ☐ Other:_____ |

Details:_____
_____

Please check with an √ any conditions you are currently experiencing, and mark with an **X** any previous conditions you have experienced.

**Hair and Skin:**

| | | |
|---|---|---|
| ☐ Acne/pimples | ☐ Eczema | ☐ Psoriasis |
| ☐ Allergies | ☐ Hair loss/thinning | ☐ Rashes/hives |
| ☐ Brittle hair/nails | ☐ Hematomas/easy | ☐ Ulcerations |
| ☐ Contagious conditions | bruising | ☐ Other_____ |
| ☐ Dry skin/scalp | ☐ Itchiness | |

Details_____
_____

**Head, Eyes, Ears, Nose and Throat:**

☐ Concussions
☐ Dizziness
☐ Headaches
☐ Migraines
☐ Pressure/stuffiness in head
☐ Glasses/contacts
☐ Poor/blurry vision
☐ Spots in front of eyes
☐ Eye pain
☐ Dry eyes
☐ Itchy eyes
☐ Red eyes
☐ Earaches
☐ Poor hearing
☐ Ringing in the ears/tinnitus
☐ Nose bleeds
☐ Sinus problems
☐ Chronic sore throat
☐ Dry throat
☐ Hoarseness/loss of voice
☐ Bleeding gums
☐ Grinding teeth
☐ Teeth problems
☐ Tongue/mouth ulcers
☐ Facial pain
☐ Jaw problems/TMJ
☐ Other_____

Details_____

_____

**Respiratory:**

☐ Asthma
☐ Bronchitis
☐ Chronic cough
☐ Difficulty breathing
☐ Emphysema
☐ Frequent common colds
☐ Pneumonia
☐ Production of phlegm, colour_____
☐ Shortness of breath
☐ Snoring
☐ Tuberculosis
☐ Wheezing
☐ Sensitivity (to cold, dryness, heat, humidity, or wind)
☐ Other_____

Details_____

_____

**Cardiovascular:**

☐ Angina
☐ Arrhythmia
☐ Chest pain
☐ Heart murmurs
☐ High blood pressure
☐ Low blood pressure
☐ Palpitations/flutter
☐ Phlebitis
☐ Stroke
☐ Varicose veins
☐ Cold hands/feet
☐ Swollen hands/feet
☐ Other_____

Details_____

_____

**Gastrointestinal:**

☐ Constipation
☐ Diarrhea
☐ Belching/hiccups
☐ Gas/bloating
☐ Nausea/vomiting
☐ Changes in appetite
☐ Indigestion
☐ Heartburn
☐ Hemorrhoids
☐ Blood in stools
☐ Ulcers
☐ Gall bladder/liver disease
☐ Special diet/allergies
☐ Weird tastes in mouth
☐ Cravings (for bitter, salty, sour, sweet)
☐ Other_____

Details_____

_____

**Genito-Urinary:**

☐ Frequent urination
☐ Frequent urination at night
☐ Painful urination
☐ Frequent UTI's
☐ Blood in urine
☐ Kidney stones
☐ Kidney disease
☐ Scanty/heavy urination
☐ Dark coloured urination
☐ Other_____

Details_____

_____

**Neuro Psychology:**

☐ Anger
☐ Anxiety
☐ Apathy
☐ Depression
☐ Difficulty
☐ focusing/concentrating
☐ Easily irritated
☐ Excessive worrying
☐ Fears
☐ Insecurity
☐ Mood swings
☐ Nervousness
☐ Poor memory
☐ Sadness
☐ Sighs
☐ Stress
☐ Suicidal thoughts
☐ Psychiatric medications
☐ Other_____

Details_____

_____

**General:**

☐ Poor/excess appetite
☐ Poor sleep
☐ Strong thirst (cold or hot drinks)
☐ Night sweats
☐ Sweat easily
☐ Chills
☐ Sensitivity to weather
☐ changes
☐ Cravings
☐ Weight loss/gain
☐ Weak immune system
☐ Other_____

Details_____

_____

**Lifestyle:**

☐ Regular Exercise
☐ Regular meals
☐ Vegetarian
☐ Alcohol
☐ Coffee/tea/soft drinks
☐ Cigarettes
☐ Addictive drugs

Details_____

_____

**Medications, Vitamins, and Herbs:**

_____

_____

_____

**Surgeries, Hospitalizations, X-Rays, CAT Scans, and MRI's:**

_____

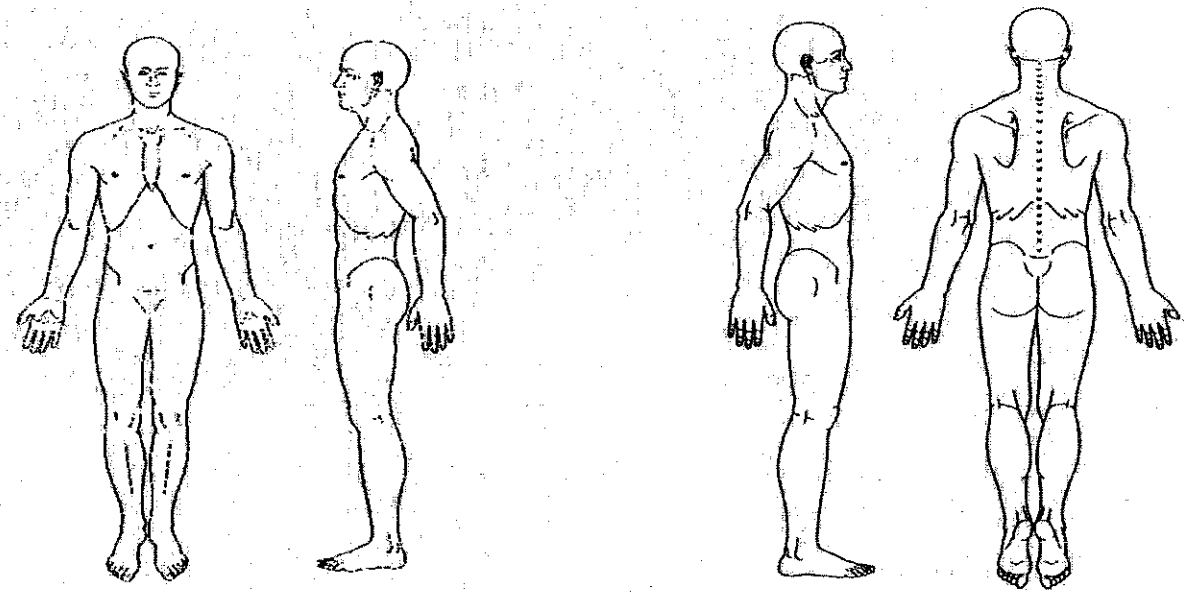
_____

_____

**Musculo-Skeletal:**

☐ Arthritis, type_____
☐ Osteoporosis
☐ Bursitis
☐ Tendonitis
☐ Stiff joints
☐ Injuries_____
☐ Swollen joints
☐ Fractures
☐ Muscle weakness
☐ Muscle pain
☐ Spasms/cramps
☐ Heaviness/numbness/ tingling
☐ Strains/sprains
☐ Other_____

Please indicate on diagram areas of concern:



Details_____

_____

**Male Reproductive:**

☐ Late puberty
☐ Diminished/increased
☐ libido
☐ Genital pains
☐ Impotence
☐ Nocturnal emission
☐ Premature ejaculation
☐ Prostate disorders
☐ Other_____

Details_____

_____

**Female reproductive:**

☐ Is there any chance you are pregnant?_____
☐ Birth control, type_____
☐ Breasts lumps/pain
☐ Irregular cycles
☐ Heavy/light flow
☐ Dark/pale blood
☐ Clotting
☐ Bleeding between cycles
☐ Premenstrual problems
☐ Painful periods
☐ Diminished/increased
☐ libido
☐ Hot flashes
☐ Menopause
☐ Vaginal discharge
☐ Difficulty conceiving
# of pregnancies_____
# of miscarriages_____
# of abortions_____
☐ Other_____

Details_____

_____