Hol Health Harmony and Houston Spinal Clinic Confidential Health Questionnaire

Fax: **Consultation**
Date: _____
E-mail: **Consultation**
Time: _____

***** All of your personal information will remain strictly confidential! *****

Name: _____
E-mail Address: _____
Street Address:
_____
_
City/State/Zip:
_____
_
Home Phone: _____ Work/Cell Phone:
_____
Date of Birth: _____ Place of Birth:
_____
Age: _____ Gender: _____ Height: _____ Current Weight: _____
Would you like your weight to be different? _____ If so, what?
_____
Occupation: _____ How many hours do you work per week? _____
Relationship Status: _____ Children?
_____
Blood Type (if known):_____

Referred by:_____
_____

Please list in order of importance your top 3-5 health concerns:
_____
_____
_____
_____
_____
_____

Do you smoke? _____ How much & how often?
_____

Do you drink alcohol? _____ How much & how often? _____-
_____

What role does exercise play in your life?
_____

How much water do you drink per day?
_____

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription/non- prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts: _____
_____
_____
_____
_____

What allergies to medications?

Please list any surgeries or reasons for being under a doctor's care_____
_____
_____

Please briefly explain eating habits (do you eat out, cook, etc)

Family Health History: (List diabetes, heart disease, cancer, autoimmune illnesses)
Mother
Father
Grandmother(s)
Grandfather(s)

WOMEN ONLY:

Age of your first period: _____ Are your periods regular? _____
How frequent? _____ # of pregnancies _____
How many days is your flow? _____-
_____
Do you experience PMS? _____ Is it mild or severe? _____

Are you peri-menopausal? _____ When did this change first occur? _____
Are you menopausal? _____ When was your last period? _____
List your symptoms of peri/menopause:
_____
_____
_____
_____
_____

Please list any pregnancies or complications incurred by a pregnancy:

Health Check list – Please answer **"Y"** or **"N".** Leave blank if symptom does not apply

General Symptoms:	**Ears:**	**Eyes:**
Allergies - Colds- Depression - Fatigue - Fainting spells - Insomnia - Frequent illness -	Itchy ears - Earaches - Ear Infections - Ringing in Ears - Ear Drainage - Hearing Loss -	Watery Eyes - Itchy or red eyes - Blurred Vision - Tunnel Vision -
Nose:	**Emotions:**	**Heart/Cardiovascular:**
Stuffy nose - Sinus problems - Hay Fever - Sneezing - Excess Mucus - Nose Bleeds -	Mood Swings - Anxiety - Nervousness - Anger - Irritability - Depression -	Irregular heartbeat - Rapid heartbeat - Chest pains - Swelling of ankles - Poor Circulation - High/Low blood pressure -
Joint/Muscle:	**Head:**	**Lungs/Respiratory:**
Joint pain - Arthritis - Muscle pain - Varicose veins - Back pain -	Dizziness - Headaches -	Chest congestion - Asthma - Shortness of breath - Bronchitis - Chronic Cough -
Mind:	**Disabilities:**	**Mouth/Throat:**
Poor memory - Confusion -	Stuttering - Poor concentration -	Chronic Sore throat - Swollen gums -

Learning -		Canker sores - Sensitive teeth-nerves -
Energy: Fatigue - Apathy - **Lethargy:** Hyperactivity - Restlessness -	**Digestive Tract:** Nausea - Diarrhea - Constipation - Bloating - Belching - Excess Gas - Heartburn/Reflux -	**Urinary Tract** Bladder trouble - Kidney failure - Kidney infection - Kidney stones - Prostate trouble - Chronic UTI's - Burning urination -
Skin: Acne - Boils - Hives or rashes - Hair loss - Excess sweating - Dryness - Eczema or psoriasis - Sensitive skin - Bruising easily -	**Weight:** Binge eating - Cravings - Excessive weight - Compulsive eating - Water retention - Under weight - Eating disorders -	**Women:** Genital itch/discharge- Fibrocystic breasts - Hysterectomy - Irregular pap tests - Yeast infections - Vaginitis – Endometriosis - Absence of period - Infertility -

Note any other issue such as food allergies, illnesses, family history or concern: