CONFIDENTIAL HEALTH QUESTIONNAIRE

Hi and thank-you for taking time to fill in this questionnaire. This gives me valuable insight into your history and overall health picture. Please circle applicable answers. This information is strictly confidential and will be treated with respect.

Today's Date: ____________

Name: ______________________________

Address: ______________________________

Phone: (H) __________ (W) __________ Fax: __________

E-mail: ______________________________

Birth date: (Yr)_____ (Mnth)_____ (Day)_____ Age: ______

Marital Status: Married Partnered Single Separated/Divorced/Widowed

Children (Name & Age): ______________________________

Live with: Spouse/Partner Children Parents Alone

Friends Pets Other Family: ______________

Emergency Contact: ______________________________

Occupation/Employer: ________________ Hrs/wk ________

____

Hobbies: ______________________________

Other Healthcare Providers: MD__________ ND__________

DC__________ RMT__________

Other______________________

Height: _______ Blood Type: _______

Weight: _______ Max Weight Past Year: _______

Min Weight Past Year: _______

Allergies (food, drugs, other): ______________________________

EXERCISE

Frequency: __________ Duration: ___________

Type: ____

DIET

How many: Meals daily? _______ Snacks daily? _______

Typical: Breakfast _________________ Lunch _____________________

Dinner ________________________ Snacks _____________________

Favorite foods: ____

Food Cravings: ____

Foods you avoid: ____

Water: Daily amount: ___________ Tap Purified

Coffee / Tea / Cola: No Yes; Amount _________

OTHER LIFESTYLE

Pharmaceutical medication: _______________________________________

Over-the-counter medication: ______________________________________

Supplements: ____

____

Alcohol / Drugs: No Yes; Amount _______ Quit; How long ago? ________

Cigarette smoker? Never Yes; Amount ______ Quit; How long ago? ________

Your regular stress level: Low Moderate High

Stressors: ____

How do you relax? ____

How Often? ____

FAMILY HEALTH HISTORY

Significant illnesses: (Please indicate relative beside applicable conditions)

Allergies	Alzheimer's	Arthritis	Asthma
Blood Pressure	Cancer	Depression	Diabetes
Hay fever/Hives	Hepatitis	Heart Disease	Kidney Disease
Seizures	Thyroid	Tuberculosis	Stroke

Other: ____

YOUR HEALTH HISTORY

Significant illnesses: (Please write date beside applicable conditions.)

Arthritis	Asthma	Blood Pressure Problems	Cancer	Depression
Diabetes	Hepatitis	Heart Disease HIV	Kidney Disease	
Seizures	Thyroid	Tuberculosis	STDs	Stroke

Other: ____

Surgeries: ____________________ Trauma (accidents, falls etc): __________________

Other Injuries: ____

CURRENT HEALTH - What are your main health concerns at this time?

1) ____

2) ____

3) ____

4) ____

5) ____

Please circle any symptoms that are present or recurring.

GENERAL

Fevers / chills	Poor sleep	Fatigue	Night sweats
Sweat easily	Tremors	Cravings	Weakness
Poor balance	Weight loss / gain	Bleed / bruise easily	Strong thirst
Peculiar taste/smell	Sudden energy drop (what time of day?) _________		

GASTROINTESTINAL Bowel movements. How often? _________

Nausea Indigestion Bloating Vomiting Belching Farting

Constipation Abdominal pain Diarrhea Hemorrhoids Bloody stools

Black stools Ulcer IBS Gall bladder Bad Breath Liver disease

Chronic laxative use Other gastro: ______________________________

SKIN & HAIR

Rashes Acne Itching Dandruff Ulcerations Hives Eczema

Recent moles Hair loss Splitting skin Other? ______________________

HEAD REGION

Dizziness Concussions Light headed Migraines Other headaches

Swollen glands Sore throats Glasses / contacts Eye strain Night blindness

Cataracts Spots in visual field Ringing ears Poor hearing Earaches

Nose bleeds Sinus problems Loss of smell Cavities Silver fillings

Root Canal(s) Other dental work: ______________________________

Cankers Cold sores Other: ______________________________

CARDIOVASCULAR

Chest pain High/low blood pressure High cholesterol Murmurs

Irregular heartbeat Palpitations Cold hands / feet Swelling hands/feet

Blood clots Shortness of breath Dizziness Bleed/bruise easily Anemia

Varicose veins Hemorrhoids Other cardio: ____________________

RESPIRATORY

Cough Coughing blood Asthma Pleurisy Wheezing

Bronchitis Shortness of breath Pneumonia Phlegm (color?) __________

Other respiratory: ____________________________

URINARY SYSTEM

Frequent urination Painful / burning urination Incontinence Decrease in flow

Kidney stones Waking to urinate. How often? _________ Stop / start flow

Particular color / odor to urine? _________ Bloody urine Urgency

Other U/G: ______________________________

MUSCULOSKELETAL

Muscle pain   Muscle weakness   Back pain   Neck pain   Stiffness

Joint pain? Where? ______________________   Arthritis   Inflammation

Broken bones   Other: ______________________

NEUROLOGICAL

Seizures   Dizziness   Poor / loss of balance   Numbness / tingling   Uncoordinated

Concussion   'Spacey'   Poor memory   'Fuzzy-brained'   Stressed

Anxiety / nervous   Depression   Irritable / quick temper

Past / presently treated for emotional problems   Have considered or attempted suicide

Other emotional / neurological issues: ______________________

FEMALE

Average length of monthly cycle: ______   Duration of period: _______

Number of pregnancies: _______   Number of births: _______

Irregular periods

Heavy periods   Light periods   Painful periods   Spotting b/w periods

Abnormal PAP   Colored vaginal discharge. Color?_______   Yeast infection

STD? _________   Ovarian cysts   Fibroids   Endometriosis

Painful intercourse   Birth control pill   Practice birth control (method?): ____________

Low libido   Breast lumps   Breast soreness   Breast self exam

Menopause symptoms: ______________________

Other female issues: ______________________

MALE

Hernias   Prostate disease   Impotence   Frequent urination   Stop / start flow

Decreased flow   Painful / burning urination   Feeling 'not emptied'   Vasectomy

Waking to urinate. How often? ________   Discharge   STD?________

Other male issues: ______________________