

PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name: _____ Date: _____

Purpose of this appointment _____

Have you been seen by other physicians for this problem? _____

If yes, what physicians? _____

Have you ever tried or do you currently use (name technique or practitioner):

Chiropractic _____

Massage Therapy _____

Acupuncture and Oriental Medicine _____

Naturopathic medicine _____

Other Wholistic therapies _____

Psychotherapy _____

Other _____

How does this problem affect your life? _____

Please list up to 8 major health concerns in order of importance:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

FAMILY HISTORY

Please state if anyone in your family has or has had any of these diseases:

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma/Hayfever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alzheimers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Neurological | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Allergies | |

CURRENT MEDICATIONS Please include the dosages if available For Doctor Use Only

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |
| 7. _____ | _____ |
| 8. _____ | _____ |

CURRENT VITAMINS AND SUPPLEMENTS

For Doctor Use Only

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Please check if you have now or have had in the past, any of these symptoms.

ALLERGIES Please list any known allergies next to the item

For Doctor Use Only

<input type="checkbox"/> Drugs _____	<input type="checkbox"/> Chemicals _____	_____
<input type="checkbox"/> Foods _____	<input type="checkbox"/> Animals _____	_____
<input type="checkbox"/> Environmental _____	<input type="checkbox"/> Other _____	_____
What happens when you have an attack? _____		_____
_____		_____
Have you ever had allergy testing? _____		_____
When? _____		_____
By Whom? _____		_____
What kind of test? _____		_____

RESPIRATORY

<input type="checkbox"/> Frequent colds and flus	<input type="checkbox"/> Swollen glands	_____
<input type="checkbox"/> Sore throats	<input type="checkbox"/> Chest congestion	_____
<input type="checkbox"/> Fevers		_____
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Itchy eyes	_____
<input type="checkbox"/> Nasal drip	<input type="checkbox"/> Ear aches	_____
<input type="checkbox"/> Nose bleeds frequent	<input type="checkbox"/> Laryngitis	_____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Wheezing	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Difficulty breathing	_____
<input type="checkbox"/> Cough	<input type="checkbox"/> Pain on breathing	_____
Color of sputum _____	<input type="checkbox"/> Emphysema	_____
Thin or thick mucous _____	<input type="checkbox"/> Positive TB test ever?	_____
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Shortness of breath when	_____
<input type="checkbox"/> Shortness of breath lying	exercizing	_____
down	<input type="checkbox"/> Air hunger	_____
<input type="checkbox"/> Shortness of breath in cold	<input type="checkbox"/> Sigh frequently	_____

GENERAL WEIGHT

For Doctor Use Only

- Overweight
- Underweight
- Weight gain
- Weight loss
 - Height _____
 - Weight _____
- Where do you tend to gain weight? _____
- Is it difficult to loose or gain weight? _____
- Diets you have tried _____
- Desire to loose or gain weight _____

ENERGY

- What is you energy level on a scale of 1-10? 10 being the highest. _____
- Fatigue _____
- Tired after eating
- More energy in the evening
- Morning person
- Night person
- How many hours of sleep do you get per night? _____
- Difficult to fall asleep
- Wakes at night and can't fall back to sleep
- Slow starter in the AM
- What time of day does energy drop? _____
- Insomnia
- Chronic fatigue _____
- Reduced initiative/ motivation
- Desires naps in the middle of the day
- Remembers dreams
- Nightmares
- Wakes at night to urinate
- Wakes rested
- Wakes tired

TEMPERATURE

- Body temperature is
 - Warm
 - Cold
 - Alternating
- Prefers
 - Warm weather
 - Cool weather
 - Warm drinks
 - Cold drinks
- Flush easily
- Night sweats
- Sweats easily
- Hotflashes
- Cold hands and feet
- Aversion or Intolerance to
 - Heat
 - Cold
 - Wind
 - Damp
- Slight fever sensation in body
- Afternoon fevers
- Abnormal thirst

PAST MEDICAL HISTORY Please List

For Doctor Use Only

List any disease you have had or have now

Immunizations and vaccines

Surgeries and dates

Hospitalizations and dates

Fractures and dates

Accidents and dates

Traumas

LIFESTYLE

For Doctor Use Only

Date of last physical

What type of exercise do you do

How often do you exercise

Do you smoke?

How many packs per day?

How many years?

How many alcoholic drinks do you drink per week?

What recreational drugs do you do?

What hobbies and activities do you do in your free time

Relaxation activities

