PERSONAL HISTORY

Dear Patient, welcome to our office, this form is designed to help us to get the cause of your current health problem as quickly as possible. The more detailed and accurate you are, the better care we can provide. Your overall health is just as important to us as your current major complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goals.

Date: _____ E-mail: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Business phone: _____ Birth date: _____

Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of work: _____

Check one: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Referred to this office by: _____

Current Medications: ☐ Tranquilizers ☐ Pain Killers/Muscle Relaxants ☐ Blood Pressure

☐ Insulin ☐ Aspirin/Similar ☐ Hormones ☐ Other

Specific drug or substance: _____

Natural Remedies: Vitamins/Minerals: _____

Herbs: _____

Homeopathics: _____

CURRENT HEALTH CONDITIONS

Date of last doctor visit: _____ Condition treated: _____ Last medical Physical: _____ Most recent blood work: _____

Check any of the following conditions you have experienced other than your current major complaints:

1. MUSCULO-SKELETAL

	Past	Present	Mild	Moderate	Severe
Low back pain	◇	◇	◇	◇	◇
Pain between shoulders	◇	◇	◇	◇	◇
Neck	◇	◇	◇	◇	◇
Arm pain/numbness/weakness	◇	◇	◇	◇	◇
Joint pain/stiffness	◇	◇	◇	◇	◇
Walking problems	◇	◇	◇	◇	◇
Muscle cramps	◇	◇	◇	◇	◇

	Past	Present	Mild	Moderate	Severe
Leg pain/numbness/weakness	◇	◇	◇	◇	◇
General stiffness	◇	◇	◇	◇	◇
Fractures	◇	◇	◇	◇	◇
Foot/ankle problems	◇	◇	◇	◇	◇
Difficult chewing/clicking jaw	◇	◇	◇	◇	◇
Shoulder problems	◇	◇	◇	◇	◇
Knee problems	◇	◇	◇	◇	◇
Hip problems	◇	◇	◇	◇	◇

2. NERVOUS SYSTEM

☐ Nervousness:
Do you consider yourself to be a "nervous type" in general? _____
Are you feeling nervous about something specific? _____

☐ Forgetfulness:
Are you forgetting recent events? _____ Events from distant past? _____
Do you forget other things? _____ Is memory worse with stress? _____

☐ Numbness:
Where? _____ When did it start? _____

Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

☐ Dizziness: ☐ Past ☐ Present

☐ Fainting ☐ Past ☐ Present

☐ Stress ☐ Past ☐ Present
If present, what areas of your life do you consider to be stressful? _____

☐ Depression: ☐ Past ☐ Present
If present, how long have you been depressed? _____

Have you ever taken prescribed medications for depression? ☐ Yes ☐ No
If yes, list medications: _____

Are you getting professional counseling? ☐ Yes ☐ No Is there a family history of depression? ☐ Yes ☐ No

Is your current depression related to a specific situation? ☐ Yes ☐ No

Is your depression: ☐ Mild ☐ Moderate ☐ Severe

☐ Cold or Tingling Extremities: ☐ Hands ☐ Feet ☐ Both Date of onset: _____

Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

3. GENERAL

☐ Fatigue: ☐ Past ☐ Present If present: ☐ Mild ☐ Moderate ☐ Severe Daily? ☐ Yes ☐ No
Is there a pattern? Describe:_____

☐ Headaches: ☐ Past ☐ Present If present, how frequent: ☐ Daily ☐ Weekly ☐ Monthly

Degree: ☐ Mild ☐ Moderate ☐ Severe Location of pain: _____
Is there a pattern? Describe: _____

How long has this pattern of headaches existed (days/weeks/months/years)? _____

Do you have any idea what causes or triggers your headaches? _____

Females only: Is there a relationship to your menstrual cycle? ☐ Yes ☐ No

☐ Allergies: ☐ Airborne ☐ Food ☐ Unknown
List Known Allergies: _____

How Often? Daily/Weekly/Monthly If seasonally, which seasons? _____

What kind of symptoms do you have with your allergies? _____

☐ Bleeding Tendencies: Where? _____ How Often? _____ How Severe? _____

☐ Loss of Sleep: ☐ Past ☐ Present If present, how frequently does this occur? _____

Do you have difficulty falling asleep or staying asleep? (circle one or both) ☐ Yes ☐ No
What other factors do you think cause or influence this condition? _____

☐ Skin Conditions: ☐ Past ☐ Present
Describe Condition: _____
List past treatments and effectiveness: _____

☐ Fever:
When was your last fever? _____
How often do you get fevers? _____
How severe do they get? _____

4) GENITRO URINARY

☐ Bladder Infections:
When was your last one? _____ How often do you have one? (per year) _____
What factors do you think cause or influence this condition? _____

☐ Frequent Urination: (other than associated with bladder infections) How frequent? (times per day) _____ (times per night) _____

☐ Discolored Urine: ☐ Past ☐ Present If present, When did it begin? _____ Is there an odor? _____

☐ Incontinence: ☐ Past ☐ Present If present, when did it begin? _____

☐ Dribbling ☐ Past ☐ Present If present, when did it begin? _____

☐ Blood in Urine: ☐ Past ☐ Present If present, when did it begin? _____

5. CARDIOVASCULAR/RESPITORY

☐ Chest Pain: ☐ Past ☐ Present If present, when does it occur? _____
Treatment? _____

☐ Shortness of Breath: ☐ Past ☐ Present
When does it occur? _____

☐ Heart Disease: ☐ Past ☐ Present
Describe: _____

☐ Ankle Swelling: ☐ Past ☐ Present If present, is it constant? _____

☐ Blood Pressure Problems: ☐ Past ☐ Present ☐ High ☐ Low
Medication? _____

☐ Lung Problems/Congestion:
Describe: _____

☐ Stroke: When? _____ Residual Problems? _____

☐ Chronic Cough: When did it start? _____ Are you a smoker? _____

☐ Irregular Heartbeat/Murmurs (circle one or both)
Describe: _____
Have you seen a medical Dr. for this? _____ What did they say? _____

☐ Varicose Veins: ☐ Past ☐ Present When did they start? _____ Are they painful? _____
What aggravates them? _____

6. EYES, EARS, NOSE AND THROAT

☐ Vision Problems: ☐ Past ☐ Present Specify Problem: _____ When did it begin? _____
List treatments: _____

☐ Earaches/Infections ☐ Past ☐ Present When was the last episode? _____
How often do they occur? _____ Severity of the problem? _____
List treatment: _____

☐ Dental History:
List present problems: _____ Past problems: _____
Have teeth been pulled? _____ Infections? _____ Fillings? _____ Bridge or crowns? _____ Braces? _____

☐ Hearing Difficulty: ☐ Past ☐ Present Please describe: _____
When did it begin? _____ List any treatment and its effectiveness: _____

☐ Sore Throat: ☐ Past ☐ Present If present, when did it begin? _____ How severe is it? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____

☐ Nose and Sinus Problems: ☐ Past ☐ Present Describe: _____
When did it begin? _____ How severe is it? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____

☐ Noises in Ear: ☐ Past ☐ Present Describe: _____
When did it begin? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____

7. GASTRO-INTESTINAL

☐ Poor/Excessive Appetite (circle one or both): ☐ Past ☐ Present When did it start? _____

Do you feel you have an unhealthy relationship with food? ☐ Yes ☐ No Are you a compulsive eater? ☐ Yes ☐ No

Have you ever been considered: ☐ Anorexic ☐ Bulimic

Do you feel over-concerned or obsessed with you weight and/or body image? ☐ Yes ☐ No

☐ Constipation: ☐ Past ☐ Present If present, when did it begin? _____ Is this a lifetime pattern? ☐ Yes ☐ No

What do you think causes or influences this condition? _____

Do you take any medications or natural substances to assist you in bowel function? (please list) _____

_____

☐ Diarrhea: ☐ Past ☐ Present If present, frequency: ☐ Occasional ☐ Intermittent ☐ Constant

When did it start? _____ Is it related to: ☐ specific foods ☐ stress

What do you think causes or influences it? _____

☐ Gall Bladder Problems: ☐ Past ☐ Present If present, describe symptoms:_____

☐ Liver Problems: ☐ Past ☐ Present If present, describe symptoms:_____

☐ Heartburn: Frequency: ☐ Occasional ☐ Intermittent ☐ Constant

All foods? _____ Only certain foods? (please list) _____

Is there a time of the day when it is worse? _____

☐ Excessive Thirst: ☐ Past ☐ Present When did it begin? _____

☐ Weight Change: As an adult, what has your weight range been? High: _____ Low: _____ What is your goal weight? _____

☐ Black/Bloody Stool: ☐ Past ☐ Present When did it start? _____

☐ Ulcers: When? _____ Treatment? _____

☐ Nausea: ☐ Past ☐ Present If present, frequency: ☐ Occasional ☐ Intermittent ☐ Constant

Time of day: _____ Certain foods? _____ Other factors? _____

☐ Vomiting: ☐ Past ☐ Present If present, when did it start? _____

☐ Hemorrhoids: ☐ Past ☐ Present Are they: ☐ Painful ☐ Bleeding

What factors affect it? _____

☐ Abdominal Cramps/Pain: ☐ Past ☐ Present If present, location: _____

When do they occur? _____ Intensity: ☐ Mild ☐ Moderate ☐ Severe

☐ Hepatitis: ☐ Past ☐ Present Type?_____ When did it start? _____

☐ Crohns/Colitis/IBS/IBD: ☐ Past ☐ Present If present, when did it start? _____

☐ Gas/Bloating After Meals: ☐ Past ☐ Present If present, all meals? ☐ Yes ☐ No

8. FEMALE PROBLEMS

Your age at first period? _____ Date most recent period began? _____

How many days do you flow? _____ Is flow? ☐ Heavy ☐ Normal ☐ Light ☐ None How many days from period to period? _____

Last PAP smear? _____ History of abnormal PAP? ☐ Yes ☐ No If abnormal, what class? _____

Any treatment? _____

Contraception: (present) _____

Past history of birth control use? How long? _____ Any side effects? _____

Number of pregnancies: _____ Live births: _____ Are you pregnant now? ☐ Yes ☐ No ☐ Unsure

☐ Menstrual Cramping: ☐ Mild ☐ Moderate ☐ Severe

☐ Do you get cramps every month? ☐ Yes ☐ No If not, how often? _____

☐ Spotting: During period? ☐ Yes ☐ No Between periods? ☐ Yes ☐ No

☐ PMS: (Pre-menstrual syndrome) ☐ Yes ☐ No If yes: ☐ Mild ☐ Moderate ☐ Severe
How many days of symptoms before your period? _____

Check the symptoms that apply: ☐ Breast tenderness ☐ Food cravings ☐ Irritability ☐ Crying easily ☐ Bloating/weight

☐ Suicidal ☐ Other: _____

☐ Painful Intercourse: ☐ Past ☐ Present

☐ Breast Lumps/Fibrocystic: ☐ Past ☐ Present

☐ Vaginal Infections/Yeast: ☐ Past ☐ Present Frequency, how many times per year? _____

☐ Sexual Dysfunction: ☐ Past ☐ Present Describe: _____

☐ Ovarian, Vaginal or Uterine Problems: ☐ Past ☐ Present

☐ Infertility: ☐ Past ☐ Present Treatment: _____

9. MALE PROBLEMS

☐ Prostate Problems: ☐ Past ☐ Present
If present, describe symptoms: _____ When did this begin? _____
List any treatment and its effectiveness: _____

☐ Incomplete Voiding of Urine: ☐ Past ☐ Present If present, describe symptoms: _____
When did this begin? _____ List any treatment and its effectiveness: _____

☐ Pain During Urination ☐ Past ☐ Present
If present, describe symptoms: _____ When did this begin? _____
List any treatment and its effectiveness: _____

☐ Sexual Dysfunction: ☐ Past ☐ Present
If present, describe symptoms: _____ When did this begin? _____
List any treatment and its effectiveness: _____

10. DISEASE

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ Venereal Disease	☐ Genital Warts
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Asthma	☐ Herpes
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Anemia	☐ Heart Disease
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy/Seizures	☐ Thyroid	☐ Measles
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder	☐ Eczema	☐ German Measles/Rubella

11. Have you been treated for any other condition not covered in this questionnaire? (please describe) _____

_____

_____

When? _____

12. SLEEP HABITS: Average hours per night? _____ Is it quality sleep? ☐ Yes ☐ No

Do you awake refreshed? ☐ Yes ☐ No Do you awake tired and exhausted? ☐ Yes ☐ No

13. BOWEL MOVEMENTS: Times per week: _____ Color: _____ Consistency: _____

14. DIET

Please describe your diet by indicating how many times per day/week/month you consume the following:

Eggs	_____	times per _____	Salad	_____	times per _____
Milk Products	_____	times per _____	Coffee	_____	times per _____
Wheat Products	_____	times per _____	Tea (caffeinated)	_____	times per _____
Pasta	_____	times per _____	Alcohol	_____	times per _____
Bread	_____	times per _____	Chocolate	_____	times per _____
Rolls/Muffins	_____	times per _____	Other Sweets	_____	times per _____
Red Meat	_____	times per _____	Soft Drinks	_____	times per _____
Chicken	_____	times per _____	White Flour Products	_____	times per _____
Fish	_____	times per _____	Water	_____	times per _____
Wild Game	_____	times per _____	Fried Foods	_____	times per _____
Fresh Vegetables	_____	times per _____	Cigarettes	_____	times per _____
Frozen Vegetables	_____	times per _____	Grains	_____	times per _____
Canned Vegetables	_____	times per _____			
Fresh Fruit	_____	times per _____	Food Craved: _____		
Frozen Fruit	_____	times per _____	_____		
Canned Fruit	_____	times per _____			
			Meals per day: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6		

15. EXERCISE

Type_____ Frequency _____ times (day or week) Duration _____

Type_____ Frequency _____ times (day or week) Duration _____

Type_____ Frequency _____ times (day or week) Duration _____

Type_____ Frequency _____ times (day or week) Duration _____

I understand and agree that my health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, outstanding charges for professional services rendered me will be immediately due and payable.

Client's Signature: _____ Date: _____

Guardian or Spouses

Signature Authorizing Care: _____ Date: _____