ADULT PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: ____
Last *First* *M.I.*

Date of Birth: _____________________ Age: _______ Gender: (circle one) F M

Emergency Contact:

____
name *relationship to patient*

Contact Info: Please *circle the preferred number* to contact you:

Home #:____________________________ Cell #:________________________

E-mail:_________________________________

Home/ Billing Address: ____

____

Name and address of physician's office or hospital/ clinic that keeps your other medical records:

____
Office/Hospital/Clinic *City, State, Zip*

*Natural medical healthcare is possible only when the Practitioner completely understands the patient's physical, mental and emotional condition. The information you provide helps the practitioner understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and feel free to ask any questions.

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your most important health concerns?

1)________________________________ 2) ________________________________

3)________________________________ 4)________________________________

Context of Care

Successful healthcare and preventive medicine require a healthy relationship between provider and patient. In order to fully assist you in this journey, I need to have an understanding of you on physical, mental/emotional, and spiritual levels. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty will help both of us to assess an appropriate course of treatment that is specific to you and your needs.

Why did you choose to come to our clinic?

What do you know about our approach to healthcare?

What *three* expectations do you have of *today's* visit to our clinic?

What *long-term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your healthcare provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle habits? *Rate from 0-10, where 10 is 100% committed.*

0 1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you engage in regularly that support your health and well-being?

What behaviors or lifestyle habits do you believe are self-destructive or hinder your ability to heal or be healthy?

What potential obstacles do you foresee getting in the way of you addressing the lifestyle factors that are undermining your health and adhering to the treatment guidelines we will give to you at this clinic?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

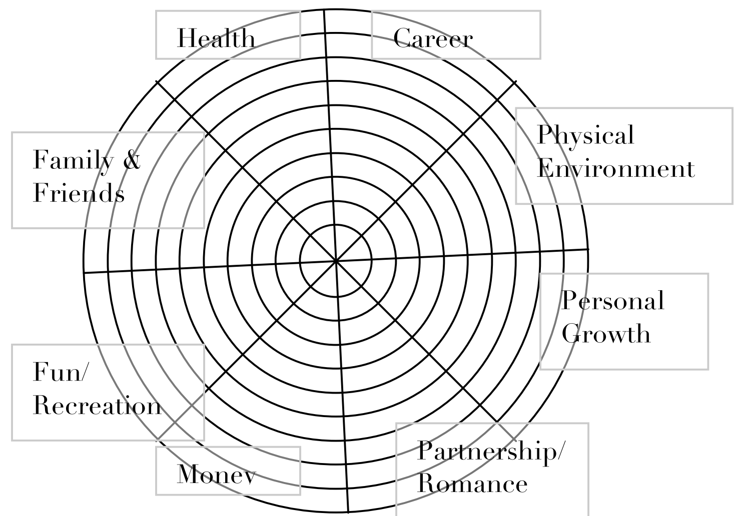
What do you love to do?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied with your career, shade in 6 levels of the career slice.

Do the same for each area, starting from the center and shade outwards.



MEDICATIONS

Circle those that apply

Pain Relievers	Sleeping Aids	Anti-histamine
Antacids	Heart/Blood	Antidepressants
Laxatives	Medication	Birth Control Pills
Thyroid Medication	Antibiotics	

Other ____

CHILDHOOD ILLNESSES:

Circle those that apply

Chicken Pox	Scarlet fever	Bronchitis	Asthma
Measles	Pneumonia	Rubella	Mumps
Frequent colds	Eczema	Croup	Ear infections
Tonsillitis			

Are any of the conditions for which you check "yes" recurrent conditions? _______
Other: _________________________________

IMMUNIZATIONS

Measles	DPT	Polio	Other
Mumps	Small Pox	Tetanus	____________
MMR	Diphtheria	Influenza	____________

Did you have any adverse reactions to immunizations? (Please specify)

Did you ever have any of the above contagious diseases? If yes, which one(s)? _________
____

Do you have any known contagious diseases at this time? If yes, what? _______________

INJURIES/SURGERIES/HOSPITALIZATIONS *(procedure and date)*

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal G.parents
Ages (if living)							
Current Health							
Age @ Death							
Cause Of Death							

Have any of your close relatives had any of the following diseases? If so, please indicate who/ what the relationship is to you.

Cancer____________________

Diabetes__________________

Stroke____________________

Alzheimer's________________

Mental Illness______________

Kidney Disease_____________

Autoimmune Disease________

Heart Disease_________________

High Blood Pressure___________

Epilepsy______________________

Glaucoma____________________

Tuberculosis__________________

Arthritis______________________

Other________________________

HEALTH REVIEW

Circle the response that applies

Y: condition now
N: condition never had
P: condition had in the past

Have a supportive relationship?	Y N P
History of abuse?	Y N P
Any major traumas?	Y N P
Use recreational drugs?	Y N P
Been treated for drug dependence?	Y N P
Enjoy your work?	Y N P
Spend time outside?	Y N P
Watch television?	Y N P
How many hours?__________	
Read?	Y N P
How many hours? __________	
Do you drink alcoholic beverages?	Y N P
Interests and hobbies ___________________	
Do you exercise:	Y N P
If yes, what kinds: _______________________	

MENTAL-EMOTIONAL

Treated for emotional problems?	Y N P
Have mood swings?	Y N P
Considered/attempted suicide?	Y N P
Have poor concentration?	Y N P
Fear, phobias?	Y N P
Increased irritability?	Y N P
Angered easily?	Y N P
Depression?	Y N P
Anxiety/Nervousness?	Y N P
Tension?	Y N P
Memory problems?	Y N P

NEUROLOGIC

Seizures?	Y N P
Vertigo/Dizziness?	Y N P
Loss of balance?	Y N P
Numbness or tingling?	Y N P
Paralysis?	Y N P
Muscle weakness?	Y N P

Do you sleep well?	Y N P
Avg 6-8 hours?	Y N P
Wake rested?	Y N P

How many drinks/ week? _________	
Been treated for alcohol use?	Y N P
Do you use tobacco?	Y N P
How many years/ packs per day? ________	
Religious or spiritual practice?	Y N P
Take vacations?	Y N P
Do you diet often?	Y N P
Do you eat out frequently?	Y N P
Do you drink coffee?	Y N P
Do you drink soda?	Y N P
Do you like salt?	Y N P

NEUROLOGIC, Cont:

Easily stressed?	Y N P
Loss of memory?	Y N P

MUSCULO-SKELETAL

Pain?	Y N P
Stiffness?	Y N P
Swelling?	Y N P
Numbness?	Y N P
Tightness?	Y N P
Coldness?	Y N P
Burning sensation?	Y N P
Twitching/tremors?	Y N P
Shooting pains?	Y N P

RESPIRATORY

Cough?	Y N P
Sputum?	Y N P
Asthma?	Y N P
Wheezing?	Y N P
Bronchitis?	Y N P

Emphysema?	Y N P
Pneumonia?	Y N P
Coughing up blood?	Y N P
Difficulty breathing?	Y N P
Shortness of breath?	Y N P
" " While lying down?	Y N P
Pain on breathing?	Y N P
Tuberculosis?	Y N P

NOSE AND SINUS

Frequent colds?	Y N P
Stuffiness?	Y N P
Sinus problems?	Y N P
Polyps?	Y N P
Nose bleeds?	Y N P
Hayfever?	Y N P
Loss of smell?	Y N P

HEAD

Frequent headaches?	Y N P
Migraines?	Y N P
Jaw/TMJ problems?	Y N P
Feeling of heaviness?	Y N P
Head injury?	Y N P
Hair loss?	Y N P

EYES

Impaired vision?	Y N P
Cataracts?	Y N P
Glaucoma?	Y N P
Spots in vision?	Y N P
Tearing or dryness?	Y N P
Eye pain or eye strain?	Y N P

EARS

Impaired hearing?	Y N P
Earaches?	Y N P
Discharges from ears?	Y N P
Ringing in ears?	Y N P
Chronic ear infections?	Y N P

ENDOCRINE

Hypothyroid?	Y N P
Hypoglycemia?	Y N P
Excessive thirst?	Y N P
Fatigue?	Y N P
Heat/cold intolerance?	Y N P
Diabetes?	Y N P
Excessive hunger?	Y N P
Energy crashes?	Y N P
Seasonal depression?	Y N P
Difficulty exercising?	Y N P

IMMUNE

Chronic fatigue syndrome?	Y N P
Chronically swollen glands?	Y N P
Reactions to vaccines?	Y N P
Chronic infections?	Y N P
Slow wound healing?	Y N P
Night sweats?	Y N P

CARDIOVASCULAR

Heart disease?	Y N P
Angina?	Y N P
High/low blood pressure?	Y N P
Heart murmurs?	Y N P
Chest pain?	Y N P
Palpitations?	Y N P
Blood clots?	Y N P
Fainting?	Y N P
Phlebitis?	Y N P
Leg pain unrelated to injury?	Y N P
Ankle or leg swelling?	Y N P
Rheumatic fever?	Y N P

GASTROINTESTINAL

Trouble swallowing?	
Heartburn?	Y N P
Indigestion?	Y N P
Ulcers?	Y N P
Frequent Nausea?	Y N P
Frequent Vomiting?	Y N P
Diarrhea?	Y N P
Constipation?	Y N P
Bloody Stools?	Y N P
Light colored stools?	Y N P
Rectal Pain?	Y N P
Rectal itching?	Y N P
Gall Bladder disease?	Y N P
Liver disease?	Y N P
Hemorrhoids?	Y N P
Bloating?	Y N P

Belching? Y N P
Gas? Y N P
Marked thirst? Y N P
Thirstless? Y N P
Appetite change? Y N P
Eat in a hurry? Y N P
Loss of taste? Y N P
Abdominal or stomach pain? Y N P
Bowel movements-how often? _____________

MOUTH AND THROAT
Frequent sore throat? Y N P
Copious saliva? Y N P
Sore tongue or lips? Y N P
Jaw click? Y N P
Hoarseness? Y N P
Teeth grinding? Y N P
Dental cavities? Y N P
Canker sores? Y N P
Cracked lips? Y N P
Peculiar taste? Y N P
Gum Problems? Y N P

NECK
Lumps in neck? Y N P
Goiter? Y N P
Pain or stiffness in neck? Y N P
Sensation of choking? Y N P

SKIN
Rashes? Y N P
Boils or acne? Y N P
Color change? Y N P
Lumps? Y N P
Eczema, hives? Y N P
Hair loss? Y N P

URINARY
Frequent urination? Y N P
Urination at night? Y N P
Pain on urination? Y N P
Blood in urine? Y N P
Involuntary urination? Y N P
Difficulty starting urine flow? Y N P
Variation in urine stream (male)? Y N P

FEMALE REPRODUCTIVE
Age of first menses _______
Age of last menses (if menopausal) _______
Length of cycle _______
Duration of bleeding _______
Regular cycles? Y N P
Bleeding between cycles? Y N P
Heavy/excessive flow? Y N P
Clotting? Y N P
Painful menses? Y N P
Other symptoms with menses? Y N P
Pain between menses? Y N P
Endometriosis? Y N P
Bleeding between cycles? Y N P
PMS? Y N P
Symptoms? __________________________
____
Ovarian cysts? Y N P
Uterine fibroids? Y N P
Vaginal discharge? Y N P
Vaginal odor? Y N P
Pain with sex? Y N P
Date of last PAP smear? ________
Abnormal PAP's? Y N P
Cervical dysplasia? Y N P
Gonorrhea? Y N P
Chlamydia? Y N P
Herpes? Y N P
Syphilis? Y N P
Genital warts? Y N P
Are you sexually active? Y N P
Sexual orientation? _____________________
Birth control?____________________________
Difficulty conceiving? Y N P
Number of pregnancies? _______
Number of live births? _______
Number of miscarriages? _______
Number of abortions? _______
Breast self-exams? Y N P
Breast pain/ tenderness? Y N P
Breast lumps? Y N P
Nipple discharge? Y N P
Menopausal symptoms? Y N P

MALE REPRODUCTIVE
Are you sexually active? Y N P

Sexual orientation: ______________________
Birth control type: ______________________

Discharge or sores?	Y	N	P
Chlamydia?	Y	N	P
Gonorrhea?	Y	N	P
Herpes?	Y	N	P
Genital warts?	Y	N	P
Hernias?	Y	N	P
Testicular pain?	Y	N	P
Testicular masses?	Y	N	P
Difficult or loss of erection?	Y	N	P
Painful erections?	Y	N	P
Prostate disease?	Y	N	P
Infertility?	Y	N	P

BLOOD

Anemia?	Y	N	P
Easy bleeding or bruising?	Y	N	P
Thrombophlebitis?	Y	N	P
Cold hands/feet?	Y	N	P
Deep leg pain?	Y	N	P

DIET

Please describe your typical daily diet:

____

____

____

Do you have any food intolerances or allergies that you know of?
Yes No
If yes, please explain: ____

____

Please list all medications and supplements you take regularly:

____

____

____

Are there any religious or cultural beliefs or practices of which you would like us to be aware?
____

____

THANK YOU FOR TAKING THE TIME TO FILL THIS OUT COMPLETELY!