



ADULT PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____
Last First M.I.

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

Next of Kin: _____
name relationship to patient

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

Home #: _____ Work #: _____
Cell #: _____ E-mail: _____

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

Office/Hospital/Clinic Name Street/ P.O. Box

City State Zip Code

*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?

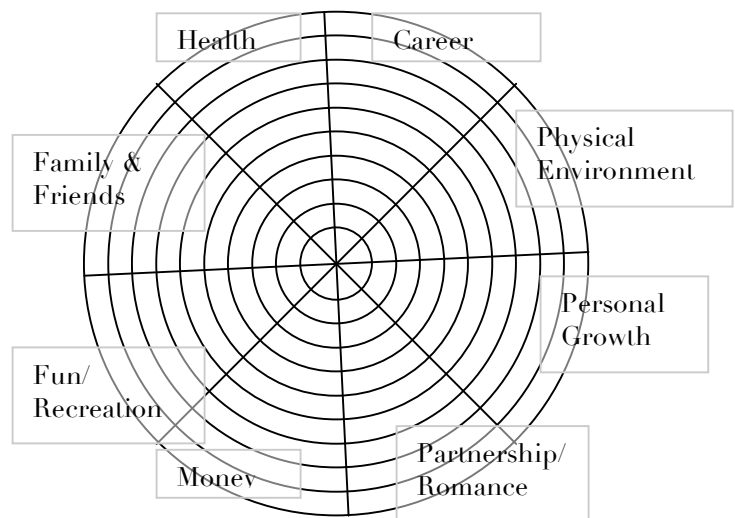
What do you love to do?

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 _____

Heart Disease _____

Diabetes _____

High Blood Pressure _____

Stroke _____

Epilepsy _____

Alzheimers _____

Glaucoma _____

Mental Illness _____

Tuberculosis _____

Kidney Disease _____

Arthritis _____

Autoimmune Disease _____

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



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Emphysema?	Y N P	Heat/cold intolerance?	Y N P
Pneumonia?	Y N P	Diabetes?	Y N P
Coughing up blood?	Y N P	Excessive hunger?	Y N P
Difficulty breathing?	Y N P	Energy crashes?	Y N P
Shortness of breath?	Y N P	Seasonal depression?	Y N P
“ “ While lying down?	Y N P	Difficulty exercising?	Y N P
Pain on breathing?	Y N P		
Tuberculosis?	Y N P		
		IMMUNE	
NOSE AND SINUS		Chronic fatigue syndrome?	Y N P
Frequent colds?	Y N P	Chronically swollen glands?	Y N P
Stuffiness?	Y N P	Reactions to vaccines?	Y N P
Sinus problems?	Y N P	Chronic infections?	Y N P
Polyyps?	Y N P	Slow wound healing?	Y N P
Nose bleeds?	Y N P	Night sweats?	Y N P
Hayfever?	Y N P		
Loss of smell?	Y N P	CARDIOVASCULAR	
		Heart disease?	Y N P
HEAD		Angina?	Y N P
Frequent headaches?	Y N P	High/low blood pressure?	Y N P
Migraines?	Y N P	Heart murmurs?	Y N P
Jaw/TMJ problems?	Y N P	Chest pain?	Y N P
Feeling of heaviness?	Y N P	Palpitations?	Y N P
Head injury?	Y N P	Blood clots?	Y N P
Hair loss?	Y N P	Fainting?	Y N P
		Phlebitis?	Y N P
EYES		Leg pain unrelated to injury?	Y N P
Impaired vision?	Y N P	Ankle or leg swelling?	Y N P
Cataracts?	Y N P	Rheumatic fever?	Y N P
Glaucoma?	Y N P		
Spots in vision?	Y N P	GASTROINTESTINAL	
Tearing or dryness?	Y N P	Trouble swallowing?	
Eye pain or eye strain?	Y N P	Heartburn?	Y N P
		Indigestion?	Y N P
EARS		Ulcers?	Y N P
Impaired hearing?	Y N P	Frequent Nausea?	Y N P
Earaches?	Y N P	Frequent Vomiting?	Y N P
Discharges from ears?	Y N P	Diarrhea?	Y N P
Ringing in ears?	Y N P	Constipation?	Y N P
Chronic ear infections?	Y N P	Bloody Stools?	Y N P
		Light colored stools?	Y N P
ENDOCRINE		Rectal Pain?	Y N P
Hypothyroid?	Y N P	Rectal itching?	Y N P
Hypoglycemia?	Y N P	Gall Bladder disease?	Y N P
Excessive thirst?	Y N P	Liver disease?	Y N P
Fatigue?	Y N P	Hemorrhoids?	Y N P
		Bloating?	Y N P



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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



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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:

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

THANK YOU

I certify that the information that I have provided is correct and accurate to the best of my knowledge.

SIGNATURE or Parent/Guardian

DATE



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