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patient information questionnaire

TODAY'S DATE

NAME (LAST, FIRST, MIDDLE)			SOCIAL SECURITY NUMBER
AGE	DATE OF BIRTH	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

HOME PHONE	EMAIL ADDRESS

HOME ADRESS		APARTMENT NUMBER
CITY	STATE	ZIP CODE

OCCUPATION	BUSINESS PHONE	MOBILE PHONE

EMPLOYED BY		
EMPLOYERS ADDRESS		
CITY	STATE	ZIP CODE

SPOUSE'S NAME

EMERGENCY CONTACT NAME		RELATIONSHIP
HOME PHONE	MOBILE PHONE	BUSINESS PHONE

Insurance Information

INSURANCE COMPANY	MEMBER ID	GROUP / PLAN NUMBER	
INSURANCE CO. ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NUMER			
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOCIAL SECURITY NUMBER	
RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Child ☐ Other _____			

ADDITIONAL NOTES / INFORMATION

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health history questionnaire I

NAME (LAST, FIRST, MIDDLE)	DATE

Please check any symptoms you have or have had in the past year.

General
- ☐ Chills
- ☐ Low Energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Fevers
- ☐ Excess Thirst
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweat Spontaneously
- ☐ Night Sweating
- ☐ Lack of Sweating
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Aversion to Heat
- ☐ Aversion to Cold

Head & Neck
- ☐ Blurred Vision
- ☐ Heaviness in the Head
- ☐ Headache
- ☐ Phlegm in Throat
- ☐ Cataract
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Eye Pain / Strain
- ☐ Corrected Vision
- ☐ Nasal Obstruction
- ☐ Nasal Discharge
- ☐ Loss of Sense of Smell
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Recurrent Sore Throat
- ☐ Red / Inflamed Eye
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Sores on Lips
- ☐ Sores on Tongue
- ☐ Taste Changes
- ☐ Teeth / Dental Problems
- ☐ Vision Problems (halos, etc.)

Respiratory
- ☐ Asthma
- ☐ Hay Fever
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Shortness of Breath
- ☐ Recurrent Bronchitis
- ☐ Phlegm Production
- ☐ Difficulty Inhaling
- ☐ Difficulty Exhaling

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ Hypochondriac Pain
- ☐ Distention in Chest or Hypochondrium

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea / Loose Stools
- ☐ Bloody Stools
- ☐ Black Stools
- ☐ Difficulty Swallowing
- ☐ Poor Appetite
- ☐ Heartburn / Reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Poor Appetite
- ☐ Stomachache
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood

Diet and Lifestyle
- ☐ Vegetarian
- ☐ Healthy Diet
- ☐ Eat Primarily Fried Foods
- ☐ Eat Primarily Meat
- ☐ Smoke Cigarettes
- ☐ Drink Alcohol
- ☐ Drink Coffee
- ☐ Use Drugs
- ☐ Crave Sweets
- ☐ Eat Sweets in Excess
- ☐ Take Melatonin
- ☐ Take Steroids
- ☐ Exercise Regularly
- ☐ Exercise Excessively

Weight
- ☐ Underweight
- ☐ Normal for Height
- ☐ Overweight
- ☐ Very Overweight

Genitourinary
- ☐ Dilute Urine
- ☐ Dark Urine
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Burning Urination
- ☐ Scanty Urine
- ☐ Profuse Urine
- ☐ Frequent Urination
- ☐ Poor Bladder Control
- ☐ Urgency to Urinate

Skin
- ☐ Thick Skin
- ☐ Thin Skin
- ☐ Broken Blood Vessels
- ☐ Blood Not Clotting
- ☐ Bruise Easily
- ☐ Discoloration
- ☐ Dark Circles around Eyes
- ☐ Bags Under Eyes
- ☐ Lumps in Groin
- ☐ Lumps underarm
- ☐ Dry Skin
- ☐ Acne
- ☐ Brittle Nails
- ☐ Premature Gray Hair
- ☐ Dry, Brittle Hair
- ☐ Hair Falling Out

Neurologic
- ☐ Fainting
- ☐ Convulsions
- ☐ Handwriting Change
- ☐ Paralysis
- ☐ Stroke
- ☐ Seizures
- ☐ Tremor
- ☐ Recent Clumsiness
- ☐ Drowsiness
- ☐ Vertigo

Emotional
- ☐ Insomnia
- ☐ Irritability
- ☐ Often Feel Angry
- ☐ Troubling Dreams
- ☐ Night Terrors
- ☐ Cry Uncontrollably
- ☐ Feel Sad Often
- ☐ Forgetful
- ☐ Mind Not Clear
- ☐ Anxiety
- ☐ Fearful
- ☐ Unrestrained Joy
- ☐ Difficulty Expressing Emotions

Men Only
- ☐ Genital Pain
- ☐ Impotence
- ☐ Genital Sores
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Nocturnal Emission
- ☐ Low Sexual Energy

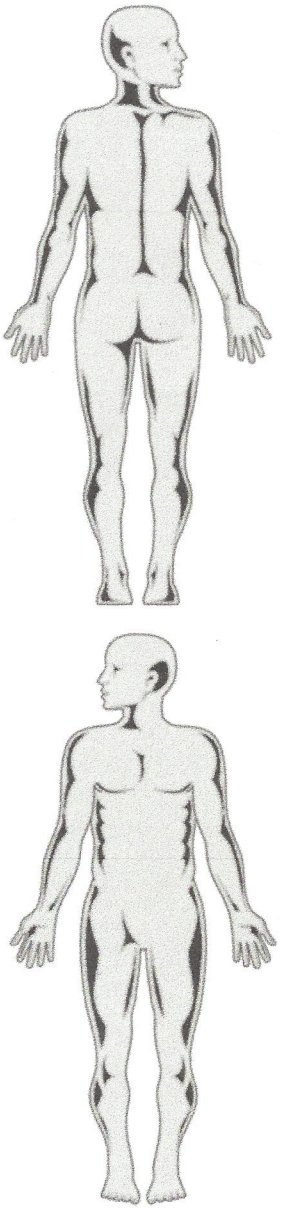
Women Only
- ☐ Abnormal pap Smear
- ☐ Bleed Between Periods
- ☐ Irregular Periods
- ☐ Heavy Period
- ☐ <25 Day Cycle
- ☐ >35 Day Cycle
- ☐ Endometriosis
- ☐ Painful Periods
- ☐ Premenstrual Tension
- ☐ Breast Lumps
- ☐ Contraceptives
- ☐ Sores on Genitalia
- ☐ Low Sexual Energy
- ☐ Vaginal Discharges
- ☐ Menopausal
- ☐ Uterine Prolapse
- ☐ Facial Hair
- ☐ Loss of Head Hair
- ☐ Possibly Pregnant

Musculoskeletal

Use the diagram below to indicate areas on your body as follows:

- **Where you feel pain or discomfort.**
- **Where you experience weakness.**
- **Where you experience numbness.**
- **Where you experience tingling.**

Use P to denote pain; W to denote weakness, N to denote Numbness and T to denote Tingling.



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health history questionnaire II

NAME (LAST, FIRST, MIDDLE)	DATE

Please check the boxes and/or respond in the best manner that describes your present condition.

Thermal Perception

- ☐Frequently feel warm.
- ☐Frequently feel cool.
- ☐Feel warm at night.
- ☐Perspire at night.
- ☐Feel cool at night.
- ☐Have cold hands and feet.
- ☐Feel hot in my face, chest or hands.
- ☐Crave cold beverages.
- ☐Crave warm / hot beverages.

Energy

- ☐I have plenty of energy.
- ☐I am tired frequently.
- ☐I experience an energy drop during the day.
  Time: _____ AM / PM
- ☐I take naps during the day.
  Number of Naps per Day: _____
  Minutes per Nap: _____
- ☐I am a slow starter in the morning.
- ☐I am a "night owl."
- ☐My energy drops after I eat.
  List types of foods that cause this: _____
  _____
  _____

Sleep

- ☐I sleep _____ hours per night.
- ☐I awaken _____ times per night on average.
- ☐I never feel rested.
- ☐I have difficulty falling to sleep.
- ☐I awaken frequently during the night.
- ☐I am a light sleeper.
- ☐I can sleep through anything and not wake up.
- ☐I sleep in on weekends to catch up on missed sleep.
- ☐Pain prevents me from sleeping.

Stress

- ☐My stress levels are very high.
- ☐My relationship with my spouse / partner causes me stress.
- ☐Work is stressful.
- ☐Many of my health complaints improve when I take vacation.
- ☐I have high blood pressure.
- ☐I have a rapid heart rate, heart palpitations or skip heart beats.
- ☐I am currently unemployed.
- ☐I dislike my job.
- ☐I have very little stress in my life.

How many ounces of water do you consume each day?

_____

Are you currently or have you ever been exposed to chemicals? (work related or personal use) YES NO
If so, what chemicals?

_____
_____
_____

Please list the quantity and frequency of use for the following items:

Tobacco _____ **per** _____
Alcohol _____ **per** _____
Coffee _____ **per** _____
Sugar _____ **per** _____
Other _____
_____ **per** _____

Please share with us any information about your health and wellness that may assist our staff in treating you:

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medical history questionnaire

NAME (LAST, FIRST, MIDDLE)	DATE

MAJOR COMPLAINT / HEALTH PROBLEM

HOW DID THIS CONDITION DEVELOP?

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? ☐Yes ☐No	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?

WHAT WERE THE RESULTS OF TREATMENT?

LIST ANY SUBSTANCES YOU ARE ALLERGIC TO:

PLEASE LIST ANY <u>MEDICATIONS OR SUPPLEMENTS</u> YOU ARE CURRENTLY TAKING ***please list additional meds on reverse*

MEDICATION	STRENGTH	HOW MANY PER DAY	FOR HOW LONG

PLEASE LIST ANY MAJOR SURGERIES YOU HAVE HAD

DATE	PROBLEMS / SURGERY

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

SIGNIFICANT ILLNESSES

☐ Arthritis	☐ AIDS	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever	☐ Thyroid Disease
☐ Asthma	☐ Cancer	☐ Gallstones	☐ Hypertension	☐ Ruptured Appendix	☐ Venereal Disease
☐ Autoimmune Disease	☐ Connective Tissue Disorder	☐ Heart Disease	☐ Kidney Stones	☐ Seizures	