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PATIENT HEALTH INFORMATION

Name ______________________ Phone #s ______________________ Email ______________________

Address ______________________ City ____________ State ________ Zip ________

Date of Birth ____________ Age ________ Place of Birth ______________ SS# ______________

Insurance Company ______________________ Policy and Group ______________________

Occupation ______________________ Work Address ______________________

In emergency notify ______________ (relationship) ____________ Phone u______________

Primary/Family Physician ____

Education/Degrees ____

Marital Status ☐Single ☐Separated ☐Divorced ☐Widow(er) ☐Married (# of times ___)

List number of children/grandchildren ____

Religious/Spiritual affiliation ____

PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE. IF SOME QUESTIONS DO NOT APPLY TO YOU, SIMPLY CROSS THEM OUT OR WRITE 'N/A' FOR 'NOT APPLICABLE'.

How did you hear about me, or whom may I thank for referring you to me? ______________________

Have you had, or are you presently receiving, any alternative or collaborative treatments (e.g., acupuncture, Oriental medicine, chiropractic care, etc.)? ______________________

____

____

Please describe your main problem in your own words, and what you would like help with. Be as specific as possible as to when it began, and what you have experienced up to the present. ______________________

____

____

____

____

To what extent does this problem interfere with your daily activities (work, play, exercise, sleep, sex)?

____

____

____

Please list type and length of treatments for this condition and practitioners involved.)

____

____

____

____

If you are presently under the care of a physician, please list the problem(s) and physician(s) caring for you.

____

____

____

____

List all medications, including prescription, over-the-counter, herbal, homeopathic, and vitamins with dosages and frequencies.) ____

____

____

____

Allergies/reactions to medications: ____

____

Vaccinations (Check all that apply.): ☐Measles ☐Mumps ☐Rubella ☐Polio ☐Smallpox ☐Tetanus ☐Diphtheria ☐Flu ☐Pneumonia ☐Hepatitis A ☐Hepatitis B ☐Gamma globulin ☐TB/BCG ☐Other ______________

Ever had a blood or blood-product transfusion? ☐No ☐Yes When and why? ______________

____

Your drinking water at home is: ☐ City/municipal ☐ Private well ☐ Filtered at home ☐ Bottled

How much do you drink daily? Coffee, regular ____ cups, decaf ____ cups Tea _____ cups

Water____ cups Soft drinks ______ cans/bottles Juice ____ cups

How much alcohol do you drink per week? Beer ____ cans/bottles Wine _____ glasses Liquor ____ oz.

Have you ever tried to reduce consumption of alcohol? ☐ No ☐ Yes

Have friends or family ever expressed concern about your drinking? ☐No ☐Yes

Have you ever felt your drinking was a problem? ☐No ☐Yes

Have you ever had an 'eye opener' (early morning drink)? ☐No ☐Yes

Ever used? ☐Marijuana ☐Cocaine ☐Hallucinogens (LSD, STP, PCP, mescaline, peyote, mushrooms) ☐Ecstasy (or other designer drugs) ☐Heroin ☐Amphetamines/Diet pills ☐Barbiturates ☐Narcotics/opiates

Tobacco use (# of times/daily cigarettes, cigars, pipes, or snuff/chewing) ____________________

How long? __________ If you used to use tobacco, when did you quit? ____________________

Have you ever seen a psychiatrist or psychologist for therapy? ☐No ☐Yes

When/why? ____________________

Have you ever received: ☐ Antidepressants ☐ Lithium ☐ ECT (electroconvulsive shock therapy)?

Describe typical daily diet.

Morning ____________________

Noon ____________________

Evening ____________________

Snacks/Supplements ____________________

Do you limit your intake of ☐ salt ☐ sugar ☐ fats ☐ dairy products ☐ other __________

List any dietary restrictions. ____________________

Describe your exercise routine. ____________________

Describe typical work routine and how you handle work/home stresses. ____________________

Do you use seatbelts? ☐No ☐Occasionally ☐Always

Do you have guns/rifles in your home? ☐No ☐Yes Are they loaded? ☐No ☐Yes

Have you traveled outside of the USA? ☐No ☐Yes Where and when ____________________

Please list serious injuries, broken bones, etc. ______________________________

____

Please list illnesses (types, dates) not requiring an operation, for which you were hospitalized. ______________

____

Any animal exposure at home or work? ☐No ☐Yes ☐Cat ☐Dog ☐Bird ☐Horse ☐Other ________

If you have had any of the following, please check box and give the approximate date of the most recent test:

☐Chest X-ray ☐Cholesterol ☐Blood Count ☐TB Skin Test
☐Rectal Exam ☐Pap Smear ☐Mammogram ☐EKG
☐PSA (Prostate blood test) ☐Complete Eye Exam

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Diabetes						
Glaucoma						
Epilepsy/Seizures						

Thyroid Disease						
Bleeding/Clotting						
Kidney Disease						
Alcoholism/Addiction						
Mental Illness						
Osteoporosis						

Cancer (list type below)						
High Cholesterol						
Arthritis						
Allergies/Asthma						
Migraine Headaches						

Other ______________________________

____

____

____

Please check the appropriate box if you have recently had problems with any of the following. If any of the symptoms were cause for concern in the past, write the year it was a problem to the left of the box.

GENERAL

- ☐ Head or chest cold
- ☐
- ☐ Current fevers
- ☐ Night sweats
- ☐ Perspire easily without exertion
- ☐
- ☐ Perspire with difficulty
- ☐ Jaundice (yellowish coloring)
- ☐ Anemia
- ☐ Always fatigued
- ☐ Fatigue easily
- ☐ Sudden drop in energy
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Often thirsty
- ☐ Seldom thirsty
- ☐ Difficulty relaxing
- ☐ Hyperactive

GASTROINTESTINAL

- ☐ Constipation
- ☐ Hard stool
- ☐ Bowel movements feel incomplete
- ☐ Frequent laxative use
- ☐ Diarrhea
- ☐ Loose stool
- ☐ Erratic bowel movements
- ☐ Foul smelling stool
- ☐ Undigested food in stool
- ☐ Blood in stool
- ☐ Black stool
- ☐ Mucus in stool
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Parasites
- ☐ Hemorrhoids
- ☐ Gas (flatulence)
- ☐ Belching
- ☐ Abdominal bloating
- ☐ Abdominal pain or cramping
- ☐ Stomach pain or cramping
- ☐ Stomach acidity/reflux
- ☐ Indigestion
- ☐ Gurgling noise in stomach
- ☐ Bitter taste in mouth
- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcer
- ☐ Hiatal hernia
- ☐ Gallstones
- ☐ Poor appetite
- ☐ Excessive appetite

What particular type of food do you often crave? ____________________

How often do you have a bowel movement? ____________________

Other problems with your digestive system or bowel movements? ____________________

SLEEP

- ☐ Difficulty falling asleep
- ☐ Shallow sleep
- ☐ Dream disturbed sleep
- ☐ Wake at night – thinking
- ☐ Wake at night – mind empty, eyes open
- ☐ Nightmares
- ☐ Snoring
- ☐ Difficulty waking in morning
- ☐ Wake up unrefreshed
- ☐ Sleepy in the afternoon
- ☐ Need to take naps
- ☐ Sleep too much
- ☐ Sleep too little
- ☐ Sleep on a water bed
- ☐ Sleep with an electric blanket

How many hours do you usually sleep over 24 hours? ________ During what hours do you sleep every 24 hours? ________

Other sleep related problems? ____________________

EYES

- ☐ Nearsighted (myopia)
- ☐ Farsighted (hyperopia)
- ☐ Astigmatism
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Night blindness
- ☐ Sensitivity to light
- ☐ Blurred vision
- ☐ Floating spots
- ☐ Pressure behind eyes
- ☐ Eye pain
- ☐ Dry eyes
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Red eyes
- ☐ Conjunctivitis
- ☐ Use eyeglasses or contacts
- ☐ Blindness

Other problems with your eyes? ____________________

HEAD, EARS, NOSE MOUTH, AND THROAT

- ☐ Frequent colds
- ☐ Sinus congestion or pain
- ☐ Facial pain
- ☐ Jaw tension or clicking (TMJ)
- ☐ Grinding teeth
- ☐ Frequent dental cavities
- ☐ Gum problems
- ☐ Bleeding gums
- ☐ Dentures
- ☐ Dizziness or loss of balance
- ☐ Concussion
- ☐ Seizures
- ☐ Headache
- ☐ Migraine headache
- ☐ Congestion in ears
- ☐ Earache
- ☐ Ringing in the ears
- ☐ Difficulty hearing
- ☐ Deafness
- ☐ Nasal Congestion
- ☐ Runny nose
- ☐ Nose bleeds
- ☐ Sneezing
- ☐ Allergies
- ☐ Decreased sense of smell
- ☐ Dry mouth
- ☐ Excessive saliva or drooling
- ☐ Sores on tongue
- ☐ Sores in mouth (canker sores)
- ☐ Sores around lips (fever blisters)
- ☐ Difficulty swallowing
- ☐ Lump or pit in throat
- ☐ Sore throat
- ☐ Strep throat
- ☐ Tonsillitis
- ☐ Swollen lymph nodes

Other problems with your head, ears, nose, mouth, or throat? ______________________________

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blackouts or fainting
- ☐ Irregular heartbeat
- ☐ Heart valve problems (murmur)
- ☐ Rapid heartbeat or palpitations
- ☐ Angina or chest pain
- ☐ Coronary artery disease
- ☐ High cholesterol
- ☐ Stroke
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Anemia
- ☐ Edema
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Cold hands
- ☐ Cold feet
- ☐ Hot hands or palms
- ☐ Hot feet or soles
- ☐ Generally too cold
- ☐ Generally too hot

Other problems with your heart or circulation? ______________________________

RESPIRATORY

- ☐ Chronic cough
- ☐ Dry cough
- ☐ Tight, rattling cough
- ☐ Loose cough
- ☐ Cough up thick, sticky phlegm
- ☐ Cough up thin, watery phlegm
- ☐ Cough up clear or white phlegm
- ☐ Cough up yellowing phlegm
- ☐ Cough up blood
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with a deep breath
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Wheezing
- ☐ Asthma – more difficult exhaling
- ☐ Asthma – more difficult inhaling
- ☐ Asthma – worse with exertion

Other problems with your lungs or breathing? ______________________________

SKIN AND HAIR

- ☐ Lashes & eyebrows
- ☐ Rashes
- ☐ Bruising
- ☐ Eczema
- ☐ Psoriasis
- ☐ Herpes zoster (shingles)
- ☐ Pimples or acne
- ☐ Ulcerations or sores
- ☐ Infections of inflammations
- ☐ Recent moles
- ☐ Recent change in moles
- ☐ Warts
- ☐ Dry skin
- ☐ Moist feet
- ☐ Moist palms
- ☐ Fungus on skin
- ☐ Fungus under nails
- ☐ Weak or brittle nails
- ☐ Hair loss
- ☐ Dandruff

Numb areas? Where? ______________________________

Other problems with your skin or hair? ______________________________

URINARY – GENITAL

- [ ] Scanty or small amount of urine
- [ ] Blood in urine
- [ ] Strong smelling urine
- [ ] Cloudy urine
- [ ] Large amount of urine
- [ ] Clear urine
- [ ] Unable to hold urine
- [ ] Urgency to urinate
- [ ] Frequent urination
- [ ] Difficulty urinating
- [ ] Decreased flow of urine
- [ ] Flow does not stop quickly
- [ ] Dribbling
- [ ] Bed wetting
- [ ] Pain or burning when urinating
- [ ] Pain in bladder area
- [ ] Blood in urine
- [ ] Bladder infection
- [ ] Kidney infection
- [ ] Kidney stones
- [ ] Sores on genitals
- [ ] Pain during intercourse
- [ ] Low sexual energy
- [ ] Excessive sexual energy
- [ ] Inability to achieve orgasm
- [ ] Prostate problems
- [ ] Low sperm count
- [ ] Ejaculation during sleep
- [ ] Premature ejaculation
- [ ] Inability to maintain an erection

How often do you urinate in 24 hours? ________ How often and at what times do you wake to urinate at night? ________

Other problems with your urinary system or genitals? ____________________

PREGNANCY AND GYNECOLOGICAL

Number of pregnancies
Number of births
Premature births
Miscarriages
Abortions
Difficult deliveries
Caesarean sections
Number of children
Age at first menses
Starting date of last menses
Duration of flow
Length of cycle
Age at start of menopause

- [ ] Hysterectomy
- [ ] Have not begun to menstruate
- [ ] Irregular cycle
- [ ] Heavy flow
- [ ] Light flow
- [ ] Clots, dark, or brownish blood
- [ ] Light colored or pale blood
- [ ] Painful periods
- [ ] Cramping before start of period
- [ ] Cramping after start of period
- [ ] Low back ache with period
- [ ] Spotting between periods
- [ ] Missed periods
- [ ] Premenstrual irritability
- [ ] Premenstrual emotional sensitivity
- [ ] Premenstrual breast sensitivity
- [ ] Premenstrual bloating
- [ ] Premenstrual fluid retention
- [ ] Premenstrual headache
- [ ] Premenstrual constipation
- [ ] Premenstrual diarrhea
- [ ] Hot flashes
- [ ] Vaginal discharge – no odor
- [ ] Vaginal discharge – foul smelling
- [ ] Vaginal discharge – brownish
- [ ] Vaginal discharge – white, curd-like
- [ ] Vaginal discharge – frothy and profuse
- [ ] Vaginal discharge – itchy
- [ ] Vaginal discharge – burning
- [ ] Abnormal PAP
- [ ] Uterine fibroids or cysts
- [ ] Ovarian cysts
- [ ] Breast cysts or lumps
- [ ] Pelvic inflammatory disease
- [ ] Currently use an IUD
- [ ] Previously have used an IUD
- [ ] Currently use birth control pills
- [ ] Previously used birth control pills
- [ ] Infertility
- [ ] Cannot maintain pregnancy
- [ ] Trying to become pregnant
- [ ] Pregnant
- [ ] Nursing
- [ ] Nausea or morning sickness

Other pregnancy or gynecological problems? ____________________

PSYCHOLOGICAL

- [ ] Depression
- [ ] Suicidal feelings
- [ ] Frequently angry or irritated
- [ ] Tend to repress emotions
- [ ] Mood swings
- [ ] Manic episodes
- [ ] Obsessiveness or compulsiveness
- [ ] Sadness or grief
- [ ] Frequent crying
- [ ] Anxiety or fear
- [ ] Indecisiveness
- [ ] Difficulty handling stress
- [ ] Poor memory
- [ ] Difficulty concentrating
- [ ] Confusion

Have you ever been emotionally, physically, or sexually abused? ____________________

Have you ever been treated for emotional problems? ____________________

Have you recently had any unusually stressful experiences (e.g., divorce, death of someone close, bankruptcy, loss of job, illness, injury, etc.)? ____________________

Is there a constant stress in your life, at work, with your family, etc.? ______________________

Other psychological problems? ______________________

MUSCULOSKELETAL

☐		☐		☐	
☐	Neck pain or stiffness	☐	Mid back pain or stiffness	☐	Leg or calf cramping
☐	Shoulder blade pain	☐	Low back pain or stiffness	☐	Ankle pain or stiffness
☐	Upper arm pain or stiffness	☐	Hip joint pain or stiffness	☐	Foot or toe pain or stiffness
☐	Elbow pain or stiffness	☐	Pain into thigh or upper leg	☐	Numbness or tingling in feet
☐	Wrist pain or stiffness	☐	Pain into calf or lower leg	☐	Muscle spasms
☐	Hand or finger pain or stiffness	☐	Weak legs	☐	Muscle weakness
☐	Numbness or tingling in hands	☐	Knee pain or stiffness	☐	Paralysis
☐	Upper back pain or stiffness	☐	Weak knees	☐	Stiffness and pain all over

Is the problem helped by ☐pressure ☐heat ☐cold ☐other ______________________

Is the problem aggravated by ☐pressure ☐heat ☐cold ☐damp weather ☐windy weather ☐other __________

Other pains or problems with your muscles, tendons, or bones? ______________________

____

COMMENTS

Please list any other problems you want to discuss or comments you want to make. ______________________

____

____

____

PAIN INDEX QUESTIONNAIRE

How long have you had neck pain? _______ years _______ months _______ weeks

How long have you had back pain? _______ years _______ months _______ weeks

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY:	A = ACHE	B = BURNING	N = NUMBNESS
	P = PINS AND NEEDLES	S = STABBING	O = OTHER