Health History Form

The information requested below will assist in treating you safely and provide a broad scope of your current health. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Date:_____

Last name:_____**First name:**_____**Middle name:**_____

Preferred/common name: _____

Phone: Home/Work (_____) _____-_____; Cell (_____) _____-_____

Address:_____
Occupation:_____ **Date of Birth (D/M/Y): _____/_____/_____**

Emergency contact:_____**Relationship:**_____

Phone: ( )_____-_____

❑ I have completed my own questionnaire

*If the patient is unable to complete this form, please provide the following information:
History written/recorded by: _____Relationship to patient:_____

What is the primary health problem that you would like help with? When did your symptoms begin? *Please be specific*

Regarding your primary problem, how often is it present? (eg. constant, comes and goes, with use, at rest)

How does the problem interfere with your daily activities? (eg. work, sleep, play, exercise, daily routine)

What makes the problem worse or better? What kind of self-care treatments have been helpful? (ice, heat, hot bath, home TENS unit, stretching, rest etc.)

What type of pain or discomfort do you experience from the problem? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Stiff ☐ Aching ☐ Tingling ☐ Throbbing ☐ Swelling Other_____

Have you been given a diagnosis for this problem?

YES NO ***If yes, what is the diagnosis, who gave the diagnosis?***

Have you received any treatment for this problem?

YES NO

Please list the physicians (primary care, specialists, surgeons), nurse practitioners, physical therapists, naturopaths, acupuncturists, chiropractors, Rolfers, massage therapists etc.

Has there been an event, trauma, surgery, or other incident (emotion or physical) that has significantly changed your life?

I would describe my health as: (circle one of the following)

EXCELLENT VERY GOOD GOOD FAIR POOR I'M NOT SURE

EXERCISE HISTORY

Please list activities and occurrence (i.e. swimming, hiking, brisk walks, running, gym classes, lift weights, bicycling, rowing, dance etc.)

- ❑ **Almost every day**
- ❑ **At least 2, 3, 4 times a week**
- ❑ **Maybe once a week**
- ❑ **Hey, who has time to exercise?**
- ❑ **My medical condition prevents me from participating in regular exercise**

FAMILY HISTORY MEDICAL HISTORY: (cancer, diabetes, high/low blood pressure, heart disease etc.):

Please check boxes for any condition that you are experiencing or have experienced

☐ Tendonitis/Bursitis
☐ Dislocated joints_____
☐ Muscle & Joint pain_____
☐ Sprains/Strains
☐ Arthritis - OA/RA
☐ Herniated discs
☐ Swelling, Stiffness of joints
☐ Osteoporosis
☐ Headaches / Migraines
☐ Brain bleed
☐ Hydrocephalus
☐ Tooth / Jaw/ TMJ / Ear Pain
☐ Hearing loss / Ringing ears / Tinnitus
☐ Bruxism (teeth clenching or grinding)
☐ Vision problems
☐ Chronic cough
☐ Chest pains
☐ Shortness of breath
☐ Bronchitis
☐ Asthma
☐ Emphysema
☐ Pneumonia

☐ Sinus problems
☐ High / Low blood pressure
☐ Phlebitis
☐ Stroke
☐ Heart disease
☐ Heart palpitations
☐ Anaemia
☐ Lymphedema
☐ Deep vein thrombosis
☐ Varicose veins
☐ Cold hands / feet
☐ Pins / needles in extremities
☐ Hepatitis
☐ Tuberculosis
☐ HIV/AIDS
☐ Chronic Yeast / Fungal Infection
☐ Kidney stones/ kidney disease
☐ Bladder/ urinary tract problems
☐ Fibromyalgia
☐ Chronic fatigue
☐ Dizziness / Vertigo / Fainting
☐ Thyroid disease (Hyperthyroid / Hypothyroid)
☐ Tuberculosis (TB)
☐ Lyme disease

☐ Loss of smell / taste
☐ Trouble swallowing
☐ GERD/Reflux Esophagitis/Gastritis
☐ Poor digestion
☐ Constipation
☐ Diarrhea
☐ IBS
☐ Abdominal pain
☐ Colitis
☐ Ulcer
☐ Hemorrhoids
☐ Liver disease
☐ Gallbladder problems_____
☐ Neurological conditions
☐ Epilepsy, Convulsions
☐ Diabetes: Onset,Type 1, Type 2
☐ Allergies - **anaphylaxis Y / N**
☐ Cancer_____
☐ Anxiety / Depression
☐ Anorexia / Bulimia
☐ Eczema / Psoriasis
☐ Bruise easily
☐Other_____

Women
☐ Pregnant - due date:_____
☐ Number of children (natural or C-section) _____
☐ Menstruation: Painful/Heavy/Light/Normal/Irregular/Absent/PRegnant
☐ Breast Tissue: Swollen/Painful/Cystic/Abnormal sensation/Other
☐ Menopause: Pre/Active/Post

Men
☐ Prostate: enlarged / surgery

MEDICATIONS AND SUPPLEMENTS

Please list <u>all</u> medications, supplements, vitamins, minerals, herbs, or remedies that you take on a *daily or regular basis and for what condition:*

Allergies (medications, foods, environmental etc. and your reactions to them):

PAST SURGICAL HISTORY/OPERATIONS

- ❑ **I have never had surgery. I have all my "original equipment"**
- ❑ **I have had surgery.** *Please list with approximate dates:*

Special Considerations:

☐ Pacemaker ☐ Rods, Pins, Wires ☐ Artificial joints/limbs ☐ Other:

INJURY HISTORY

Have you ever had any fractures/broken bones? YES NO
Have any fractures been set or fixed surgically? YES NO
Please list the bone(s) broken and the date:

Have you ever had a head injury, concussion, or other forceful blow to your head?
YES NO
If yes, please give details of the incident and the dates:

Have you had any other significant accidents for falls? *If yes, please give the details of the incident and the dates*

SOCIAL HISTORY

Do you currently smoke tobacco?
YES / NO

Have you ever smoked tobacco in the past? YES / NO

Do you use recreational drugs (including marijuana)?
YES / NO

Do you drink alcohol? YES / NO

Do you drink any caffeinated beverages? YES / NO

How many hours do you normally sleep? _____hours
How many hours do you need to function normally?
_____ hours

What is you sleep position? *Check as many as apply.*

- ❑ **On my back**
- ❑ **I'm all over the place**
- ❑ **On my stomach**
- ❑ **On my right side**
- ❑ **On my left side**

Do you ever have trouble sleeping?
YES / NO

- ❑ **I have problems falling asleep**
- ❑ **I wake up sometimes in the night, and have difficulty falling back to sleep**
- ❑ **I wake up frequently in the night**

Do you ever use sleeping pills? YES / NO
Do you ever use alcohol to help you sleep? YES / NO

***Do not write on this page. For clinician notes.**