

Client Health History

General Information

Name _____ Birthdate _____ Age _____ Gender _____
 Address _____ Postal Code _____
 Telephone: Home _____ Work _____ May leave message? Y N
 Occupation _____ Employer _____
 Practitioner name and phone _____ Last physical exam _____
 Laboratory tests performed? _____ Your blood type _____
 How did you hear about our clinic? _____
 Email Address: _____

NOTE: This questionnaire is intended to provide a well-rounded perspective of your current health and well being. There will be opportunity to elaborate on any questions. All information is kept confidential.

Major Health Concerns

What is your main reason for coming in today? _____

Please list other health concerns in order of importance to you:

Concern	Since	Details

Current treatments, including any medications taken (prescription or over-the-counter):

Treatment	Since	Provider

Your Health History

Please list any surgeries, injuries, hospitalizations or diagnostic procedures you have had:

Occurrence	Since	Details/Complications

Please list the most significant stressful events in your life. Are any of these events continuing to impact you?

Are you currently, or have you in the past, worked with a counsellor, psychologist, social worker, pastor or other therapist? Y N When?_

Do you use any of the following? If so, how often?

Antacids: _____ Laxatives: _____ Drugs: _____ Over the Counter Meds: _____

Tobacco: _____ Alcohol: _____ Caffeine: _____ Hormones: _____

Abscesses	Diabetes	Kidney Disease	Pneumonia	Syphilis	
Abortion	Emphysema	Leukemia	Rheumatic Fever	Tonsillitis	
Alcoholism	Epilepsy	Malaria	Rubella	Thyroid problem	
Allergies	Gall Stones	Measles	Scarlet Fever	Tuberculosis	
Amnesia	Goiter	Miscarriage	Sexual Abuse	Typhoid Fever	
Arthritis	Gout	Mononucleosis	Skin Disease	Venereal Warts	
Asthma	Hay Fever	Mumps	Strep Throat	Warts	
Bronchitis	Heart Disease	Parasites	Sinusitis	Whoop. Cough	
Cancer	Hepatitis	Pelvic Inflamm. Dz.	Sunstroke	Worms	
Chicken Pox	HIV	Peritonitis	Stroke	Yellow Fever	
Cold Sores	IBS	Pleurisy	STI		
Depression	Influenza				

Which of the following conditions have you had? Please indicate "now (n) or past (p)":

List any other major conditions you've had: _____

From all of the above are there any conditions or life events after which you have never felt totally well again, or which have been more severe than usual? Please describe: _____

Have you ever had a reaction to a vaccination? _____

Are you aware of any contact with environmental hazards (e.g. chemicals, pollutants, etc.) at the workplace, home, or during leisure activities?
 If so please describe. _____

What is your main drinking water source? City (tap), Spring, Reverse Osmosis.

Family Health History

In the following table, please indicate which of the following ailments, have affected your relatives.

Relative	Age (If living)	Age at death	Ailments and Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles			

General Health

Please answer the following questions or circle the option which best applies to you.

You currently live with? SPOUSE, PARTNER, PARENTS, FRIEND, CHILDREN, ALONE

Ages of children _____

Present weight? _____ One year ago? _____ Current energy level (1=poor, 10=excellent)? _____

Alcoholism	Cancer	Gout	Mental Illness	Thyroid Disease
Allergies	Depression	Hight Blood Pressure	STI	Tuberculosis
Arthritis	Diabetes	Heart Disease	Stroke	Ulcer
Asthma	Epilepsy	Hypoglycemia		

Which of the following do you experience? Please indicate “now (n) or past (p)”:

difficulty holding urine		difficulty passing urine		pain with urination		burning with urination		blood in urine		kidney stones	
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Other Symptoms

Which of the following do you experience? Please indicate “now (n) or past (p)”:

Rashes		Dry Skin		Headaches		Swollen Glands		Heart Flutters	
Acne		Chest Pain		Sinus Problems		Wheezing		Ankle Swelling	
Easy Bruising or Bleeding		Persistent Itching		Muscle Cramps		Joint Pain		Numbness Or Tingling	
Excess Thirst Or Hunger				Difficulty Breathing				Canker Sores	

Female Reproduction

Age at first menses? _____

Are your cycles regular? Y N

Average number of days? _____

Is your period? HEAVY, MEDIUM, LIGHT

Is blood? LIGHT RED, DARK RED, MEDIUM, CLOTTED

Is there spotting between periods? Y N

Do you experience any of the following related to your cycle?

water retention		headaches		depression		mood swings	
breast tenderness		irritability		cravings		other	

Do you get vaginal itching? Y N

Do you get vaginal discharge? Y N

Do you get breast lumps? Y N

Number of pregnancies _____ abortions _____ miscarriages? _____

Have you had difficulty becoming pregnant? Y N Do you use birth control? Y N

If so, what type do you currently use? _____

Have you used birth control in the past? Y N What type? _____

Do you have any sexual difficulties? Y N

Have you ever been physically or sexually abused? Y N

Have you experienced menopausal symptoms? Y N

Do you get regular Pap smears? Y N Have any been abnormal? Y N

Male Reproduction

Do you ever experience? TESTICULAR PAIN, TESTICULAR MASSES/LUMPS

Do you have any abnormal discharge from penis? Y N Sores on penis? Y N

Any history of sexually transmitted disease? Y N

Do you wake at night to urinate? Y N Has this changed in recent years? Y N

Are you aware of any prostate problems? Y N When was your last prostate exam? _____

Do you have difficulty getting or maintaining an erection? Y N

Do you have any sexual difficulties? Y N

Have you ever been physically or sexually abused? Y N

Do you use birth control? Y N

If so, what type do you currently use? _____

Thank you for taking the time to fill in this questionnaire.

be
natural