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Health History Questionnaire

Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____

City, State, Zip: _____

Phone: _____ Alternate Phone: _____

Date of Birth: _____ Gender: _____ Relationship Status: _____ Social Security Number: _____ - _____ - _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Email address for appointment reminders: _____

Are you interested in receiving our newsletter? Yes No

How did you hear about us? _____

**In order to get a complete, holistic picture of who you are,
please complete the following questionnaire as thoroughly as possible. Thank you.**

Are you currently receiving health care? Y N

If yes, where and from whom? _____

If no, where did you last receive health care? _____

For what reason? _____

What health concerns have brought you here today?

Condition	Past Treatment
1. _____	_____
2. _____	_____
3. _____	_____

Please list in order of importance your health concerns:

1. _____ 2. _____
3. _____

Do you have any reason to believe you're pregnant? Y N

Do you have any chronic infectious diseases? Y N If yes, please explain: _____

Do you currently suffer from any chronic illnesses? Y N If yes, please explain: _____

Please list any allergies or hypersensitivities (environmental, foods, medications): _____

Please list all prescribed medications, over-the-counter medications, vitamin supplements, mineral supplements or herbal supplements

that you are currently taking: _____

Height: _____ Weight (current): _____ Weight (past maximum): _____ When? _____

What was your most recent blood pressure reading? _____ When was this reading taken? _____

Please circle any illnesses you had as a child:

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Please circle any immunizations you have had:

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: _____

Hospitalizations and Surgeries:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

X-Rays/CT Scans/MRIs/Special Studies:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Family History:	Mother	Father	Brothers	Sisters	Spouse	Children
Age: (if living, or at death)						
Health: (G=Good, P=Poor)						
Cause of death: (if deceased)						
Check any conditions below that the above family members have had:						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						

Please circle below those that you experience currently, and underline those that you have experienced in the past:

Head, Eyes, Ears, Nose and Throat: Headaches Impaired Vision Eye Pain/Strain Glaucoma Tearing/Dryness

Hay Fever Impaired Hearing Ear Ringing Earaches Sinus Problems Nose Bleeds Frequent Sore Throat

Teeth Grinding TMJ/Jaw Problems Other? _____

Respiratory: Pneumonia Pleurisy Asthma Emphysema Tuberculosis Persistent Cough Difficulty Breathing

Frequent Common Colds Shortness of Breath Other? _____

Cardiovascular: Heart Disease Heart Murmur Chest Pain Rheumatic Fever Stroke High Blood Pressure

Palpitations/Fluttering Swelling of Ankles Varicose Veins Other? _____

Gastrointestinal: Ulcers Changes in Appetite Nausea Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Abdominal Pain Hemorrhoids

Other? _____

Stools: Blood in Stool Undigested Food Diarrhea Constipation Mucous Other? _____

Urinary: Kidney Disease Painful Urination Impaired Urination Frequent Urination Kidney Stones Blood in Urine

Frequent Urinary Tract Infections Cloudy Urine Other? _____

Male Reproductive: Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge Venereal Disease

Other? _____

Female Reproductive: Irregular Cycles Breast Lumps Breast Tenderness/Swelling Nipple Discharge Vaginal Discharge

Bleeding Between Cycles Heavy Flow Clotting Premenstrual Problems Menopausal Symptoms Difficulty Conceiving

Sexual Difficulties Other? _____

Age of first menses:	# of Pregnancies:	# of Miscarriages:
# of days of flow:	# of Live Births:	# of Abortions:
Length of cycle:	Birth Control:	

Musculoskeletal: Muscle Spasms/Cramps Neck Pain Shoulder Pain Upper Back Pain Mid Back Pain Lower Back Pain

Arm Pain Leg Pain Joint Pain Other? _____

Neurological: Dizziness/Vertigo Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Other? _____

Endocrine: Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other? _____

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections

Emotional: Mood Swings Nervousness Mental Tension

Miscellaneous: Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Other? _____

Is there anything else I should know? _____

Lifestyle:

Describe your typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluid Intake (amount and type): _____

Exercise: _____

Sleep Habits: _____

Education: _____

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy your work? Y N Why/Why Not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y N Please explain: _____

Hobbies and Interests: _____

FINANCIAL POLICIES

- Payment must be made at the time of service. Payment may be made in the form of cash or check only, please. We are unable to offer credit card payment due to the high costs associated with credit card fees.
- A \$25 fee will be assessed for all returned checks.
- If you should need to reschedule or cancel an appointment, please do so at least 24 hours prior to your appointment time. If an appointment is cancelled within 24 hours or missed, please note that a \$30 missed appointment fee will be charged to your account.
- We may be able to bill your insurance company for your treatment. If we are unable to directly bill your insurance company, we will provide you with a receipt that contains all of the information needed by an insurance company to reimburse you.
- You are financially responsible for your account, regardless of insurance coverage. Accounts more than 30 days past due (after receipt of insurance payments, if applicable) will be assessed a 2% monthly fee.

INSURANCE INFORMATION:

Primary Insurance Company: _____ Cust. Service Phone

#: _____

Patient Name: _____ Date of Birth: _____

Patient's relationship to insured (circle one): self spouse child other: _____

Insured's Name (if different): _____ Date of Birth: _____

Claim/Group #: _____ SSN or ID#: _____

Secondary Insurance Company: _____ Cust. Service Phone

#: _____

Patient Name: _____ Date of Birth: _____

Patient's relationship to insured (circle one): self spouse child other: _____

Insured's Name (if different): _____ Date of Birth: _____

Claim/Group #: _____ SSN or ID#: _____

I have read and understand the above financial policies.

Signature: _____ Date: _____

Office Use Only: _____

Primary	Secondary
Copay/Coinsurance: _____	Copay/Coinsurance: _____
Annual limit?: _____	Annual limit?: _____
Notes: _____	_____
_____	Notes: _____
_____	_____