

Health Questionnaire

Name _____ Birth _____
Date _____ Address _____
City _____ State _____ Zipcode _____
Phone _____ Work/Cell _____
Emergency contact Name _____ Phone _____
Occupation _____ Marital Status _____
Height _____ Weight _____ Blood Pressure _____
Are you currently pregnant? _____ Are you needle sensitive _____
How did you find out about the clinic? _____

Main Complaint

What is your main reason(s) for coming today? Please be specific as to when it started, how often it bothers you, the problem's severity, and anything that makes it better or worse.

Past treatments for the main complaint

Are there any other problems you would like to mention?

Health History

Have you had any of the following childhood diseases?

<input type="checkbox"/> measles	<input type="checkbox"/> chickenpox	<input type="checkbox"/> whooping cough	<input type="checkbox"/> diphtheria
<input type="checkbox"/> polio	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> typhoid fever	<input type="checkbox"/> smallpox
<input type="checkbox"/> mumps	<input type="checkbox"/> scarlet fever	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> mononucleosis
<input type="checkbox"/> tetanus	<input type="checkbox"/> ear infections	<input type="checkbox"/> asthma	<input type="checkbox"/> allergies
<input type="checkbox"/> other			

As an adult?

<input type="checkbox"/> chronic colds or flus	<input type="checkbox"/> breathing difficulties	<input type="checkbox"/> diabetes
<input type="checkbox"/> throat problems	<input type="checkbox"/> ear problems	<input type="checkbox"/> vision problems
<input type="checkbox"/> heart disease	<input type="checkbox"/> circulatory disorders	<input type="checkbox"/> cancer
<input type="checkbox"/> skin problems	<input type="checkbox"/> seizure disorders	<input type="checkbox"/> mood disorders
<input type="checkbox"/> head injury	<input type="checkbox"/> weight issues	<input type="checkbox"/> urinary tract infections
<input type="checkbox"/> other		

Previous surgeries or hospitalizations (Include dates)

Please list any medications, supplements, herbal products, or naturopathic substances that you are currently taking.

Please list any drug, herb, environmental, animal, food, or material allergy.

Family History

Does any blood relative in the immediate family have any of the following?

allergies arthritis asthma heart attack diabetes
 anemia depression cancer skin disease stroke
 high BP sickle cell cataract ulcers seizures
 hypoglycemia genetic disorders _____
 other _____

Quality of Life

Please briefly describe your energy levels throughout the day. List the best and worst times.

Please briefly describe your sleep patterns. Include quality of sleep, length, times of going to bed, and waking.

Are you experiencing any work or home related stress?

How would you describe your moods most of the time?

What type of exercise do you get and how often?

Please briefly describe your diet. Include any prohibitions or special conditions.

Thanks for taking the time to fill out this important questionnaire!