

Health Questionnaire

Name _____ Birth Date _____

Address _____

City _____ State _____ Zip code _____

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

___ other

As an adult?

___ chronic colds or flus	___ breathing difficulties	___ diabetes
___ throat problems	___ ear problems	___ vision problems
___ heart disease	___ circulatory disorders	___ cancer
___ skin problems	___ seizure disorders	___ mood disorders
___ head injury	___ weight issues	___ urinary tract infections
___ 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!