



PURA VIDA HEALTHCARE
a holistic cooperative

Confidential Health Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip: _____

Hm Phone: _____ Cell Phone: _____

Wk Phone: _____ (Ok to call Work? Y N) E-mail: _____

Occupation: _____ Employer: _____ Hr/week: _____

Are you: Single Partnered Married Separated Divorced Widowed

Name of partner or spouse: _____ Phone: _____

Names and ages of children (if adult): _____

Names and ages of siblings (if child): _____

Emergency contact: _____ Phone: _____

How did you hear about our clinic? _____

When did you have your last health care visit? _____

With who? _____ What was the reason? _____

Are you currently receiving healthcare anywhere else? Y N

If yes, please give name and phone number: _____

Please list in order of importance any health concerns that you have:

1. _____
2. _____
3. _____
4. _____
5. _____

Family History Y= yes N= no P= in the past

Has any family member had the following?: If yes, please identify family member:

- Alcoholism/Addiction Y N P _____
- Anemia Y N P _____
- Asthma Y N P _____
- Cancer Y N P _____
- Diabetes Y N P _____
- Epilepsy Y N P _____
- Glaucoma Y N P _____
- Heart Disease Y N P _____
- High Blood Pressure Y N P _____
- Kidney Disease Y N P _____
- Mental Illness Y N P _____
- Pneumonia Y N P _____
- Stroke Y N P _____
- Tuberculosis Y N P _____

Were any of these a cause of death? If so, who and at what age? _____

General History

What drugs are you allergic to? _____

What foods are you allergic to? _____

Any environmental allergies? _____

Have you ever been hospitalized? Y N If yes, when and why? _____

Have you had any surgeries? Y N If yes, when and why? _____

Have you had any x-rays or special studies (i.e. ECG, EEG, ultrasound, x-ray, CAT scan, MRI)

Y N If yes, what and when? _____

Medications:

Please list any prescription or over-the-counter medications, vitamins or other supplements you are currently taking:

Name: _____ Dose(milligrams) Frequency: _____ Prescribing Doctor: _____

Please list any prescription or over-the-counter medications that you took in the past and why you stopped:

Skin

Rashes?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Eczema?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Hives?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Color changes?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Acne?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Itching?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Scalin?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Night sweats?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Changes in hair/nails?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Dryness?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Head

Headaches?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Head injury?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Migraines?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Jaw/TMJ problems?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Lightheaded?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Loss of balance?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Eyes

Eye pain?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Cataracts?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Double vision?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Dryness?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Glasses?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Glaucoma?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Contacts?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Tearing?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Night blindness?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Color blindness?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Ears

Impaired hearing?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Ringing in ears?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Earaches?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Excessive ear wax?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Discharge? Y N P Ear infections? Y N P

Nose

Post nasal drip? Y N P Nose bleeds? Y N P

Changes in smell? Y N P Hayfever? Y N P

Sinus infections? Y N P Stuffy nose? Y N P

Mouth and Throat

Frequent sore throat? Y N P Sore tongue? Y N P

Mouth sores? Y N P Gum problems? Y N P

Difficulty swallowing? Y N P Changes in taste? Y N P

Teeth grinding? Y N P Dry mouth? Y N P

Neck

Pain or stiffness? Y N P Swollen glands? Y N P

Goiter? Y N P Thyroid medication? Y N P

Respiratory

Cough? Y N P Sputum? Y N P

Spitting up blood? Y N P Bronchitis? Y N P

Wheezing? Y N P Asthma? Y N P

Difficulty breathing? Y N P Emphysema? Y N P

Pain with breathing? Y N P Pneumonia? Y N P

Shortness of breath? Y N P Pleurisy? Y N P

-while lying down? Y N P Positive TB test? Y N P

- at night? Y N P

Cardiovascular

Heart disease? Y N P Angina? Y N P

High/low blood pressure? Y N P Heart murmur? Y N P

Blood clots? Y N P Leg pain when walking? Y N P

Chest pain? Y N P Palpitations/fluttering? Y N P

Rheumatic fever? Y N P Ankle swelling? Y N P

Heart attack? Y N P Stroke? Y N P

Gastrointestinal

Belching? Y N P Blood in stool? Y N P

Change in appetite? Y N P Change in thirst? Y N P

Gallbladder disease?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Heartburn?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Gas/bloating?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Hemorrhoids?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Liver disease?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Jaundice/yellow skin?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Nausea?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Vomiting?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Diarrhea?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Constipation?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Ulcers?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Colitis/Chron's?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Diverticulosis/itis?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Bowel movement how often?	_____

Urinary

Pain on urination?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Increased frequency?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Difficult to pass urine?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Frequency at night?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Bladder infections?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Unable to hold urine?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Unable to urinate?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Kidney stones?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Endocrine

Hypothyroid?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Heat or cold intolerance?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Hypoglycemia?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Diabetes?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Excessive thirst?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Excessive hunger?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Fatigue?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Seasonal depression?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Unexplained weight loss?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Easy weight gain?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Poor appetite?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Hiatal hernia?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Immune

Slow wound healing	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Reactions to vaccines?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Chronic fatigue syndrome?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Chronic infections?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Chronically swollen glands?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Frequent cold/flu?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Neurological

Seizures?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Paralysis?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Dizziness?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Fainting?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Memory loss?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Numbness or tingling?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Trembling hands/feet?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>		

Musculoskeletal

Joint pain or stiffness?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Broken bones?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Does pain limit: -work?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Muscle spasms/cramps?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
- social life?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Arthritis?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

-exercising? Y N P
- recreating? Y N P
- sleeping? Y N P

Back/neck pain? Y N P

Circulation

Cold hands/feet? Y N P

Varicose veins? Y N P

Deep leg pain? Y N P

Anemia? Y N P

Easy bleeding/bruising? Y N P

Thrombophlebitis? Y N P

Women's Health

Age menses began: _____

Birth control? Y N P

Average length of cycle: _____ days

What type: _____

Are cycles regular? Y N P

Number of pregnancies: _____

Painful menses? Y N P

Number of live births: _____

Pain with intercourse? Y N P

Number of miscarriages: _____

Heavy bleeding? Y N P

Number of abortions: _____

Premenstrual syndrome? Y N P

Difficulty conceiving? Y N P

Clotting? Y N P

Menopausal symptoms? Y N P

Sexually active? Y N P

Vaginal dryness? Y N P

History of sexually transmitted disease?

Y N P _____

Last pap smear? _____

Was it normal? _____

Bladder infections? Y N P

Hysterectomy? Y N P

Ovarian cysts? Y N P

Endometriosis? Y N P

Pelvic inflammatory dz? Y N P

Cancer? Y N P

Anything else? _____

Men's Health

Hernias? Y N P

Testicular masses? Y N P

Penile pain? Y N P

Testicular pain/swelling? Y N P

Erectile difficulty? Y N P

Prostate issues? Y N P

Premature ejaculation? Y N P

Impotence? Y N P

Sexually active? Y N P

Birth control? Y N P

-what type? _____

History of sexually transmitted disease? Y N P _____

Anything else? _____

Mental/Emotional

Depression?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Anxiety?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Mood swings?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Excessive fears?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Excessive anger?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Fatigue?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Suicidal thoughts?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Self-harm?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Bipolar?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Schizophrenia?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
ADHD?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	ODD?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Obsessive-Compulsive?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Disordered eating?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Changes in concentration?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Mental foginess?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Hallucinations?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	History of trauma?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
History of abuse?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Substance abuse/addiction?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
Therapy?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Psychiatrist?	Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>

Personal habits

How often do you eat? _____/day	How many hours of sleep? _____/night
Do you eat sugar? Y <input type="checkbox"/> N <input type="checkbox"/>	What time to sleep/wake? _____
Do you diet? Y <input type="checkbox"/> N <input type="checkbox"/>	Do you sleep well? Y <input type="checkbox"/> N <input type="checkbox"/>
Do you eat out? Y <input type="checkbox"/> N <input type="checkbox"/>	Do you wake feeling rested? Y <input type="checkbox"/> N <input type="checkbox"/>
How much water do you drink? _____/day	Do you enjoy your work? Y <input type="checkbox"/> N <input type="checkbox"/>
Do you drink coffee? Y <input type="checkbox"/> N <input type="checkbox"/>	Do you watch TV? Y <input type="checkbox"/> N <input type="checkbox"/> _____hrs
- black/green tea? Y <input type="checkbox"/> N <input type="checkbox"/>	Do you read? Y <input type="checkbox"/> N <input type="checkbox"/> _____hrs
- cola or soda? Y <input type="checkbox"/> N <input type="checkbox"/>	Do you use computer? Y <input type="checkbox"/> N <input type="checkbox"/> _____hrs
Do you use alcohol? Y <input type="checkbox"/> N <input type="checkbox"/>	Do you have spiritual practice? Y <input type="checkbox"/> N <input type="checkbox"/>
- how much? _____	Do you exercise? Y <input type="checkbox"/> N <input type="checkbox"/>
- how often? _____	-how often? _____
Do you use drugs? Y <input type="checkbox"/> N <input type="checkbox"/>	- what type? _____
- how often? _____	Do you spend time outside? Y <input type="checkbox"/> N <input type="checkbox"/>
- what types? _____	Do you take vacations? Y <input type="checkbox"/> N <input type="checkbox"/>
Do you smoke cigarettes? Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>	Do you chew tobacco? Y <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/>
- how many? _____/day	- how much _____/day

Food cravings: _____

Foods that you avoid/don't like: _____

Current weight: _____

Ideal weight: _____

What are your main interests and hobbies? _____

What brings you joy? _____

Questions

What are your health goals?

1. _____
2. _____
3. _____

What would be different about your life if you had perfect health?

1. _____
2. _____
3. _____

What is your "theory" about what is happening with your health?

Do you believe that you can get better?

What would need to change for you to get better?

1. _____
2. _____
3. _____

Do you have time to dedicate to your health right now? Y N

How much? None A little Some A lot

Are you willing to make changes in your life right now? Y N

How much? None A little Some A lot

Do you believe you can achieve balanced health? Y N

Thank you for taking the time to complete this questionnaire. This is the first step on your path to optimal health.

Welcome.