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: __________________________________

Number and ages of children (if adult): ____

Number 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:

Condition	Y / N / P	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 ☐ N ☐ P ☐	Eczema?	Y ☐ N ☐ P ☐
Hives?	Y ☐ N ☐ P ☐	Color changes?	Y ☐ N ☐ P ☐
Acne?	Y ☐ N ☐ P ☐	Itching?	Y ☐ N ☐ P ☐
Scalin?	Y ☐ N ☐ P ☐	Night sweats?	Y ☐ N ☐ P ☐
Changes in hair/nails?	Y ☐ N ☐ P ☐	Dryness?	Y ☐ N ☐ P ☐

Head

Headaches?	Y ☐ N ☐ P ☐	Head injury?	Y ☐ N ☐ P ☐
Migraines?	Y ☐ N ☐ P ☐	Jaw/TMJ problems?	Y ☐ N ☐ P ☐
Lightheaded?	Y ☐ N ☐ P ☐	Loss of balance?	Y ☐ N ☐ P ☐

Eyes

Eye pain?	Y ☐ N ☐ P ☐	Cataracts?	Y ☐ N ☐ P ☐
Double vision?	Y ☐ N ☐ P ☐	Dryness?	Y ☐ N ☐ P ☐
Glasses?	Y ☐ N ☐ P ☐	Glaucoma?	Y ☐ N ☐ P ☐
Contacts?	Y ☐ N ☐ P ☐	Tearing?	Y ☐ N ☐ P ☐
Night blindness?	Y ☐ N ☐ P ☐	Color blindness?	Y ☐ N ☐ P ☐

Ears

Impaired hearing?	Y ☐ N ☐ P ☐	Ringing in ears?	Y ☐ N ☐ P ☐
Earaches?	Y ☐ N ☐ P ☐	Excessive ear wax?	Y ☐ N ☐ P ☐

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 ☐
Rhuematic 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 ☐ N ☐ P ☐	Heartburn?	Y ☐ N ☐ P ☐
Gas/bloating?	Y ☐ N ☐ P ☐	Hemorrhoids?	Y ☐ N ☐ P ☐
Liver disease?	Y ☐ N ☐ P ☐	Jaundice/yellow skin?	Y ☐ N ☐ P ☐
Nausea?	Y ☐ N ☐ P ☐	Vomiting?	Y ☐ N ☐ P ☐
Diarrhea?	Y ☐ N ☐ P ☐	Constipation?	Y ☐ N ☐ P ☐
Ulcers?	Y ☐ N ☐ P ☐	Colitis/Chron's?	Y ☐ N ☐ P ☐
Diverticulosis/itis?	Y ☐ N ☐ P ☐	Bowel movement how often?	____________

Urinary

Pain on urination?	Y ☐ N ☐ P ☐	Increased frequency?	Y ☐ N ☐ P ☐
Difficult to pass urine?	Y ☐ N ☐ P ☐	Frequency at night?	Y ☐ N ☐ P ☐
Bladder infections?	Y ☐ N ☐ P ☐	Unable to hold urine?	Y ☐ N ☐ P ☐
Unable to urinate?	Y ☐ N ☐ P ☐	Kidney stones?	Y ☐ N ☐ P ☐

Endocrine

Hypothyroid?	Y ☐ N ☐ P ☐	Heat or cold intolerance?	Y ☐ N ☐ P ☐
Hypoglycemia?	Y ☐ N ☐ P ☐	Diabetes?	Y ☐ N ☐ P ☐
Excessive thirst?	Y ☐ N ☐ P ☐	Excessive hunger?	Y ☐ N ☐ P ☐
Fatigue?	Y ☐ N ☐ P ☐	Seasonal depression?	Y ☐ N ☐ P ☐
Unexplained weight loss?	Y ☐ N ☐ P ☐	Easy weight gain?	Y ☐ N ☐ P ☐
Poor appetite?	Y ☐ N ☐ P ☐	Hiatal hernia?	Y ☐ N ☐ P ☐

Immune

Slow wound healing	Y ☐ N ☐ P ☐	Reactions to vaccines?	Y ☐ N ☐ P ☐
Chronic fatigue syndrome?	Y ☐ N ☐ P ☐	Chronic infections?	Y ☐ N ☐ P ☐
Chronically swollen glands?	Y ☐ N ☐ P ☐	Frequent cold/flu?	Y ☐ N ☐ P ☐

Neurological

Seizures?	Y ☐ N ☐ P ☐	Paralysis?	Y ☐ N ☐ P ☐
Dizziness?	Y ☐ N ☐ P ☐	Fainting?	Y ☐ N ☐ P ☐
Memory loss?	Y ☐ N ☐ P ☐	Numbness or tingling?	Y ☐ N ☐ P ☐
Trembling hands/feet?	Y ☐ N ☐ P ☐		

Musculoskeletal

Joint pain or stiffness?	Y ☐ N ☐ P ☐	Broken bones?	Y ☐ N ☐ P ☐
Does pain limit: -work?	Y ☐ N ☐ P ☐	Muscle spasms/cramps?	Y ☐ N ☐ P ☐
- social life?	Y ☐ N ☐ P ☐	Arthritis?	Y ☐ N ☐ P ☐

-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 ☐

Deep leg pain? Y ☐ N ☐ P ☐

Easy bleeding/bruising? Y ☐ N ☐ P ☐

Varicose veins? Y ☐ N ☐ P ☐

Anemia? Y ☐ N ☐ P ☐

Thrombophlebitis? Y ☐ N ☐ P ☐

Women's Health

Age menses began: ______________

Average length of cycle: __________days

Are cycles regular? Y ☐ N ☐ P ☐

Painful menses? Y ☐ N ☐ P ☐

Pain with intercourse? Y ☐ N ☐ P ☐

Heavy bleeding? Y ☐ N ☐ P ☐

Premenstrual syndrome? Y ☐ N ☐ P ☐

Clotting? Y ☐ N ☐ P ☐

Sexually active? Y ☐ N ☐ P ☐

Birth control? Y ☐ N ☐ P ☐

What type: ______________________

Number of pregnancies: ___________

Number of live births: __________

Number of miscarriages: ___________

Number of abortions: ___________

Difficulty conceiving? Y ☐ N ☐ P ☐

Menopausal symptoms? 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 ☐

Ovarian cysts? Y ☐ N ☐ P ☐

Pelvic inflammatory dz? Y ☐ N ☐ P ☐

Hysterectomy? Y ☐ N ☐ P ☐

Endometriosis? Y ☐ N ☐ P ☐

Cancer? Y ☐ N ☐ P ☐

Anything else? ____

Men's Health

Hernias? Y ☐ N ☐ P ☐

Penile pain? Y ☐ N ☐ P ☐

Erectile difficulty? Y ☐ N ☐ P ☐

Premature ejaculation? Y ☐ N ☐ P ☐

Sexually active? Y ☐ N ☐ P ☐

Testicular masses? Y ☐ N ☐ P ☐

Testicular pain/swelling? Y ☐ N ☐ P ☐

Prostate issues? Y ☐ N ☐ P ☐

Impotence? Y ☐ N ☐ P ☐

Birth control? Y ☐ N ☐ P ☐

-what type? ____________________

History of sexually transmitted disease? Y ☐ N ☐ P ☐ ________________________________

Anything else? ____

Mental/Emotional

Depression? Y ☐ N ☐ P ☐

Mood swings? Y ☐ N ☐ P ☐

Excessive anger? Y ☐ N ☐ P ☐

Suicidal thoughts? Y ☐ N ☐ P ☐

Bipolar? Y ☐ N ☐ P ☐

ADHD? Y ☐ N ☐ P ☐

Obsessive-Compulsive? Y ☐ N ☐ P ☐

Changes in concentration? Y ☐ N ☐ P ☐

Hallucinations? Y ☐ N ☐ P ☐

History of abuse? Y ☐ N ☐ P ☐

Therapy? Y ☐ N ☐ P ☐

Anxiety? Y ☐ N ☐ P ☐

Excessive fears? Y ☐ N ☐ P ☐

Fatigue? Y ☐ N ☐ P ☐

Self-harm? Y ☐ N ☐ P ☐

Schizophrenia? Y ☐ N ☐ P ☐

ODD? Y ☐ N ☐ P ☐

Disordered eating? Y ☐ N ☐ P ☐

Mental fogginess? Y ☐ N ☐ P ☐

History of trauma? Y ☐ N ☐ P ☐

Substance abuse/addiction? Y ☐ N ☐ P ☐

Psychiatrist? Y ☐ N ☐ P ☐

Personal habits

How often do you eat? ______________/day

Do you eat sugar? Y ☐ N ☐

Do you diet? Y ☐ N ☐

Do you eat out? Y ☐ N ☐

How much water do you drink? _________/day

Do you drink coffee? Y ☐ N ☐

- black/green tea? Y ☐ N ☐

- cola or soda? Y ☐ N ☐

Do you use alcohol? Y ☐ N ☐

- how much? _______________

- how often? _______________

Do you use drugs? Y ☐ N ☐

- how often? _______________
- what types? _______________

Do you smoke cigarettes? Y ☐ N ☐ P ☐

- how many? ____________/day

How many hours of sleep? _________/night

What time to sleep/wake? _______________

Do you sleep well? Y ☐ N ☐

Do you wake feeling rested? Y ☐ N ☐

Do you enjoy your work? Y ☐ N ☐

Do you watch TV? Y ☐ N ☐ ______hrs

Do you read? Y ☐ N ☐ ______hrs

Do you use computer? Y ☐ N ☐ ______hrs

Do you have spiritual practice? Y ☐ N ☐

Do you exercise? Y ☐ N ☐

-how often? ________________

- what type? _______________

Do you spend time outside? Y ☐ N ☐

Do you take vacations? Y ☐ N ☐

Do you chew tobacco? Y ☐ N ☐ P ☐

- 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.