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?
____measles ____polio ____mumps ____ tetanus ____other_____

As an adult?
____chronic colds or flus ____throat problems ____heart disease ____skin problems
____chicken pox ____tuberculosis ____scarlet fever ____ear infections
____whooping cough ____typhoid fever ____rheumatic fever ____asthma ____diptheria
____smallpox ____mononucleosis ____allergies ____diabetes ____vision problems
____cancer _____ mood disorders ____urinary tract infections ____breathing difficulties
____ear problems ____circulatory disorders ____seizure disorders _____head injury
____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 ____stroke ____ siezures
____anemia ____allergies ____ cancers ____ eczema ____autoimmune disorders
____high BP ____ blood disorders _____ thyroid disorders ____ multiple sclerosis
____hypoglycemia ____diabetes ____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!