Heath History Intake Form

Name	Date	Email
Age	Date of birth	Marital Status
Home address		
City	State	Zip Code

Daytime Phone	Evening Phone
Referred by	Family Physician

A. Primary Concerns (in order of importance & how long they troubled you)

B. Personal History

Do you or your family members have a history of:

	Myself	Maternal	Paternal		Myself	Maternal	Paternal
Allergies to food or drugs	❑	❑	❑	Heart Surgery	❑	❑	❑
Anemia	❑	❑	❑	Hepatitis A	❑	❑	❑
Arthritis	❑	❑	❑	Hepatitis B	❑	❑	❑
Asthma, Pneumonia, TB	❑	❑	❑	Hepatitis Non-A/Non-B	❑	❑	❑
Blood Pressure, High/Low	❑	❑	❑	HIV Exposure	❑	❑	❑
Cancer	❑	❑	❑	Implant, Prosthesis	❑	❑	❑
Chemotherapy /Radiation Treatment	❑	❑	❑	Kidney or Bladder Disease	❑	❑	❑
Chest Pain/Angina	❑	❑	❑	Mononucleosis, Jaundice, Gallstone	❑	❑	❑
Contact Lenses	❑	❑	❑	Pain in the Ear, Ringing in the Ear	❑	❑	❑
Dental Treatment Complications	❑	❑	❑	Popping, Clicking, Locking of the Jaw	❑	❑	❑

Diabetes	❑	❑	❑	Prolonged bleeding when cut	❑	❑	❑
Dizziness	❑	❑	❑	Psychiatric Treatment	❑	❑	❑
Epilepsy, Convulsions, Seizures	❑	❑	❑	Rheumatic Fever	❑	❑	❑
Fainting Feet or Ankles Swelling	❑	❑	❑	Shortness of breath	❑	❑	❑
Glaucoma, Eye Surgery	❑	❑	❑	Stroke/Cerebrovascular Accident	❑	❑	❑
Heart Attack	❑	❑	❑	Thyroid Disease or Medication	❑	❑	❑
Heart Disease/Murmur	❑	❑	❑	Ulcers, Intestinal Bleeding	❑	❑	❑
				Venereal Diseases	❑	❑	❑

History of any other diseases or problems (other illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, lifestyle conditions, addictions, alcohol, drug use, changes of weight, etc.

Family history of any other diseases or problems

Please check any recent changes or concerns in the following areas:

- ❑ Dryness (skin, lips, hair, nails, colon, cough, etc.)
- ❑ Insomnia
- ❑ Gas/bloating
- ❑ Constipation
- ❑ Muscle twitching, cramping, numb, weak
- ❑ Joint pain, cracking
- ❑ Stiffness
- ❑ Shifting, tearing pain
- ❑ Cold extremities
- ❑ Restlessness
- ❑ Worry, fear, anxiety
- ❑ Diarrhea, loose stool
- ❑ Nausea/vomiting
- ❑ Migraines
- ❑ Rashes, acne, hives
- ❑ Bruises easily
- ❑ Excess thirst
- ❑ Burning, sharp pain
- ❑ Bleeding
- ❑ Tenderness to touch
- ❑ Excess body heat
- ❑ Interrupted sleep
- ❑ Anger, rage, envy, judgment, critical
- ❑ Congestion
- ❑ Food/respiratory allergies
- ❑ Edema
- ❑ Heaviness
- ❑ Dull, vague pain
- ❑ Cold clammy hands
- ❑ Frequent urination
- ❑ Excess oily skin
- ❑ Excess sleep
- ❑ Depression, greed attachment Mental lethargy
- ❑ Coating on tongue
- ❑ Low fever Excess sleep
- ❑ Aches/pains
- ❑ Malaise
- ❑ Lethargy
- ❑ Lack of energy
- ❑ Lack of taste, appetite
- ❑ Indigestion
- ❑ Sinking stool
- ❑ Energy level
- ❑ Throat
- ❑ Eyes
- ❑ Ears
- ❑ Chest
- ❑ Lungs
- ❑ Heart
- ❑ Circulation
- ❑ Urine (clear/cloudy, burning, odor, etc.)

Females

- ❏ Menopause
- ❏ Pregnant, If yes, how many months?
- ❏ Birth control pills
- ❏ Your menstrual cycles are regular
- ❏ Heavy flow
- ❏ Moderate flow
- ❏ Light flow
- ❏ Menstrual pain
- ❏ Tender breasts and/or PMS before your period

Date of your last period

How many days does your cycle normally last?

What color is the blood?

Do you experience blood clots?

C. Medical & Practitioner History

Are you currently under a physician or other health practitioners care for a specific medical problem or condition? If so, what for? What is the name of your physician and their field of specialty?

Date of last physical examination:

What prescription drugs or medications are you currently taking? For what condition? Dosage? Side effects? Date started?

What non-prescription drugs, medications, supplements or recreational drugs are you taking?

What surgeries have you had and when?

Exercise or physical activity?

Meals

	Time of day	Food choice
Breakfast		
Lunch		
Dinner		
Beverages & snacks		

Diet ❑ Vegetarian ❑ Non-vegetarian ❑ Vegan ❑ Paleo ❑ Other