**Patient History Questionnaire** **Date: ____/____/_____**

**Name:_____**

**Street Address:_____City:_____Zip:_____**

**Phone: (Work)_____ (Home)_____**

**Sex:_____ DOB: ____/____/_____ Height: _____ Weight:____**

**Email:_____Marital Status:_____**

**Occupation:_____ How long:_____**

**Emergency Contact:_____**

**Family Physician:_____Phone:_____**

**Referred by:_____**

**Chief complaint:_____**

**When did it begin?_____**

**What kinds of treatments have you tried?_____**

**What makes it better/worse?_____**

**Significant illnesses and/or surgeries:_____**

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**Allergies (drugs, foods, etc.):_____**

**Family medical history (circle all that apply):**

**Cancer diabetes stroke high blood pressure**
**Heart disease asthma seizures allergies**

**Medications/supplements:_____**

**Average Daily Diet:**

**Breakfast:_____**

**Lunch:_____**

**Dinner:_____**

**Snacks:_____**

**Please check all that apply**

**<u>Gastrointestinal</u>**

- ☐ **Nausea**
- ☐ **Constipation**
- ☐ **Black stools**
- ☐ **Bad breath**
- ☐ **Abdominal pain**
- ☐ **Vomiting**
- ☐ **Gas**
- ☐ **Blood in stools**
- ☐ **Rectal pain**
- ☐ **Diarrhea**
- ☐ **Belching**
- ☐ **Indigestion**
- ☐ **Hemorrhoids**
- ☐ **Other_____**

**<u>Genito-Urinary</u>**

- ☐ **Pain with urination**
- ☐ **Urinary urgency**
- ☐ **Decrease in flow**
- ☐ **Urinary frequency**
- ☐ **Unable to hold urine**
- ☐ **Blood in urine**
- ☐ **Kidney stones**
- ☐ **Genital stones**
- ☐ **Impotence**
- ☐ **Walking to urinate how often?_____**
- ☐ **Other_____**

**Female Reproductive/Gynecological**

- ☐ **Pregnant. If yes, # of pregnancies_____ # of births_____**
- ☐ **Miscarriages. If yes, # of miscarriages_____**
- ☐ **Premature births. If yes, # of premature births_____**
- ☐ **Heavy menstruations**
- ☐ **Light menstruations**
- ☐ **Days between menstruations_____**
- ☐ **Date of Last menstrual period**
  **Duration_____**
- ☐ **PMS**
- ☐ **Painful periods**
- ☐ **Vaginal itching**
- ☐ **Menopause**
- ☐ **Clots**
- ☐ **Vaginal discharge**
- ☐ **Abortions**
- ☐ **Breast lumps**
- ☐ **Birth control? If yes, what/how long?_____**

**Male Reproductive**

- ☐ **Low sex drive**
- ☐ **Impotence**
- ☐ **Pain with ejaculation**
- ☐ **Discharge**
- ☐ **Prostrate trouble**
- ☐ **Premature ejaculation**
- ☐ **Other:_____**

**Musculoskeletal**

- ☐ **Neck pain**
- ☐ **Back pain**
- ☐ **Hip pain**
- ☐ **Night leg cramps**
- ☐ **Shoulder pain**
- ☐ **Muscle weakness**
- ☐ **Numbness**
- ☐ **Hand/Wrist pain**
- ☐ **Knee pain or weakness**
- ☐ **Muscle pains**
- ☐ **Foot/ankle pain**

**Other_____**

**_____**

**Neuropsychological**

- ☐ **Mood swings**
- ☐ **Lack of coordination**
- ☐ **Poor memory**
- ☐ **Bad temper**
- ☐ **Anxiety**
- ☐ **Seizures**
- ☐ **Dizziness**
- ☐ **Epilepsy**

☐ Depression
☐ Easily stressed
☐ Loss of balance
☐ Other_____
_____

Have you ever been treated for an emotional problem?_____
Have you ever considered or attempted suicide?_____

## Skin and Hair

☐ Rashes
☐ Eczema
☐ Recent moles
☐ Ulcerations
☐ Pimples
☐ Hives
☐ Dandruff
☐ Itching
☐ Hair loss, change in texture

## Head, Eyes, Ears, Nose & Throat

☐ Eye strain
☐ Night blindness
☐ Ringing in ears
☐ Chronic sore throat
☐ Concussions
☐ Eye pain
☐ Cataracts
☐ Poor hearing
☐ Grinding teeth
☐ Poor vision
☐ Sinus problems
☐ Facial pain
☐ Spots in front of eyes
☐ Earaches
☐ Nose bleeds
☐ Sores on lips/tongue
☐ Headaches. If yes, where and when?
_____
☐ Other_____
_____

## Cardiovascular

☐ High blood pressure
☐ Dizziness
☐ Cold hands and feet
☐ Low blood pressure
☐ Fainting
☐ Blood clots
☐ Chest pain
☐ Swelling of hands
☐ Phlebitis
☐ Irregular heartbeat
☐ Swelling of feet
☐ Shortness of breath
☐ Other_____
_____

**Respiratory**

- ☐ Cough
- ☐ Pneumonia
- ☐ Production of phlegm
- ☐ Coughing blood
- ☐ Pain with deep breathing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Difficulty breathing lying down
- ☐ Other lung problems_____

**Sleep**

- ☐ Trouble falling asleep
- ☐ Excessive dreaming
- ☐ Trouble staying asleep
- ☐ Waking up early

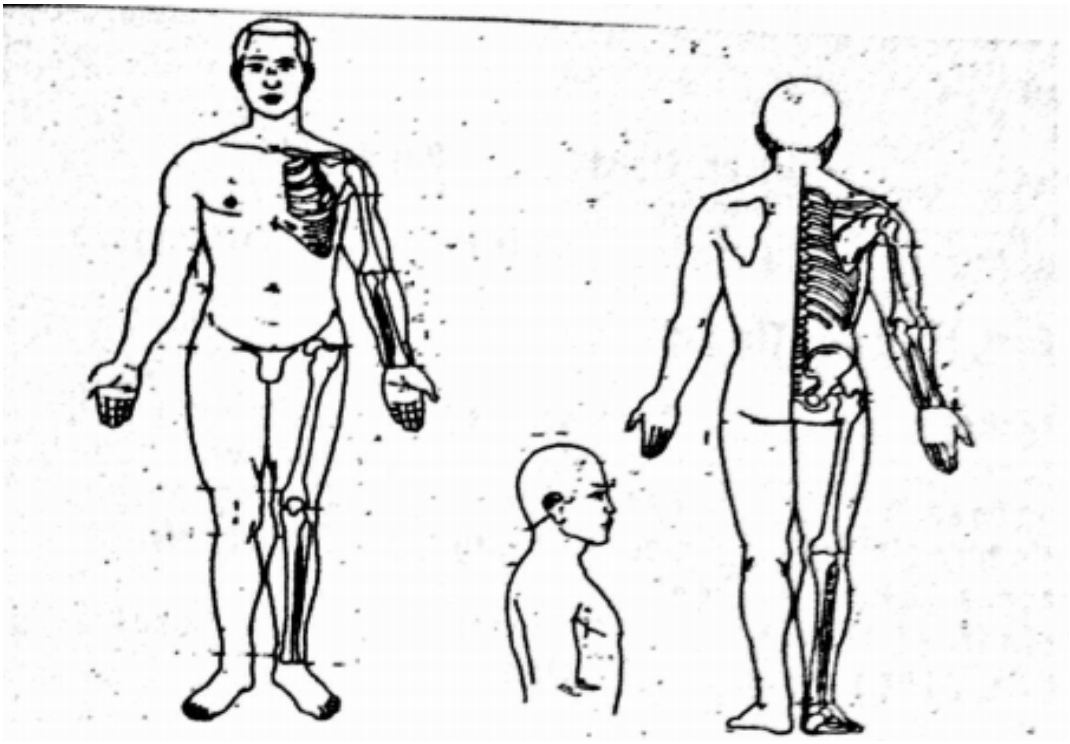
**How many hours do you sleep?_____Feel rested?_____**

**Comments:_____**

**_____**

**_____**

***Please indicate areas of pain***



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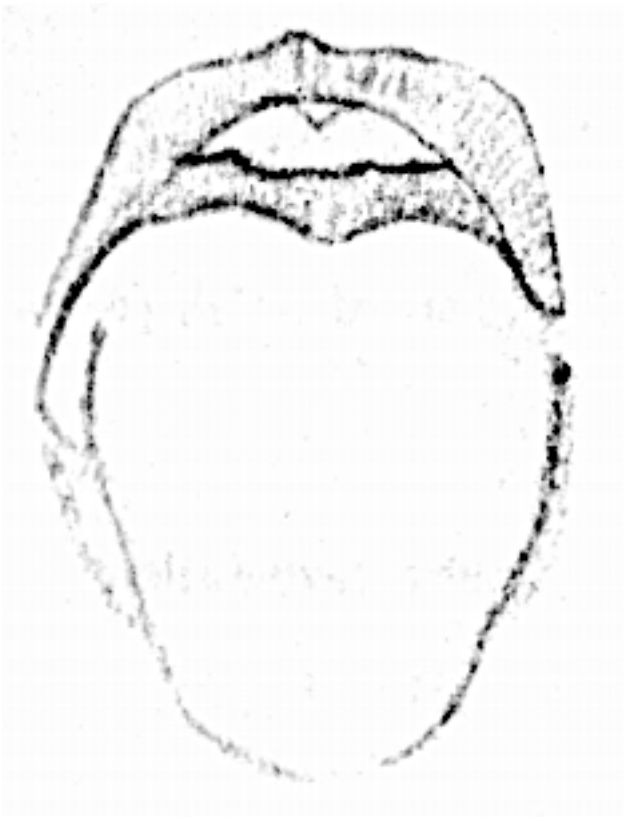

**Pulse diagnosis:**

_____
_____
_____
_____
_____

**Diagnosis:**

_____
_____
_____

**Secondary:**

_____
_____
_____

**Points:**_____
_____