Health History Questionnaire

NAME: _____ **DATE OF BIRTH**: _____ **AGE:** ___ **SEX:** _____ **RACE:** _____ **DATE**: _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

SOCIAL: Leisure Activities/Hobbies/Sports: _____ Occupation: _____Currently working: Yes/No
Marital Status: Single/Married/Divorced
Children # and Ages: _____ Number of pregnancies: _____ Are you pregnant or trying to conceive: Yes/No
Lives: Alone / Family / Roommates
Support System: Strong / Fair / Poor
Do you have a Caregiver: Yes/No
Are you a caregiver: Yes/No
Housing**:** Single Story / ___ Floors, Steps to enter ____
Do you feel safe in your home and/or work environment? Yes/No If no please explain _____

During the past month have you been feeling down, depressed, hopeless or apathetic? Yes / No _____

During the past month have you felt overwhelmed, anxious, frustrated or stressed? Yes / No _____

Do you have a history of physical, emotional or sexual trauma and/or abuse? Yes / No _____

ALLERGIES: List any medication(s) you are allergic to: _____ Are you latex sensitive? Yes/No
List any other allergies we should know about _____ Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

OTHER HEALTH CARE PROVIDERS: Please check (√) any of the following whose care you're under
___ Medical doctor (MD). ___ Osteopath. ___ Psychiatrist/Psychologist ___ Physical Therapist ___ Chiropractor. ___ Dentist
Other _____ Date of last physical examination_____
If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):
_____

SURGERIES/HOSPITALIZATIONS INCLUDE DATE AND REASON

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

1._____ _____ 2. _____ _____
3._____ _____ 4. _____ _____
5._____ _____ 6. _____ _____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS: Which of the following OVER-THE-COUNTER medications have you taken in the past week?

		Physician Prescribe	Dosage	Frequency	Specify
Aspirin	Yes/No	Yes/No			
Tylenol	Yes/No	Yes/No			
Anti-inflammatories (Advil, Aleve, Ibuprofen)	Yes/No	Yes/No			
Stomach Ulcer Meds/Antacids	Yes/No	Yes/No			
Vitamins	Yes/No	Yes/No			
Mineral/Homeopathic Supplements	Yes/No	Yes/No			
CBD/THC/Marijuana	Yes/No	Yes/No			

Are you currently taking: ___ Pain Killers (opiates) ___Muscle Relaxants ___Laxatives ___Thyroid Med ___ Hormone Replacement ___Antidepressants
___ Insulin ___Blood Pressure Med ___Mood Stabilizing Med ___Anti-anxiety Med ___Sleep Aid ___Heart Medication

Please list any other physician-prescribed medications you are currently taking (INCLUDING) pills, injections, and/or skin patches):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
Tobacco use: How many packs do you smoke per day _____ for how many years _____ If quit when? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____ How many drinks a week/month? _____

Health History Questionnaire

MEDICAL HISTORY: Please check all that apply and clarify location and type: Clarify which family member (Mom, Dad, Sibling or GP)

	Self	Family
Aortic Aneurysm		
ADD/ADHD/ASD		
Alcoholism		
Ankylosing Spondylitis		
Alzheimer's Disease		
Anxiety		
Arthritis _____		
Asthma		
Atrial Fibrillation/Arrhythmia		
Bleeding Disorders _____		
Cancer _____		
Cervical Disc Disease (Levels) _____		
Chronic Cough/COPD		
Chronic Fatigue		
Circulation Problems _____		
Colitis		

	Self	Family
Deep Vein Thrombosis (R / L)		
Depression		
Diabetes		
Drug Addiction _____		
Embolism (Pulmonary, Brain)		
Endometriosis		
Eye Conditions _____		
Fibromyalgia		
Gall Bladder Disease		
Gastroesophageal Reflux/Ulcer		
Glaucoma (narrow/wide angle)		
Gout		
Headaches/Migraines		
Heart Disease _____		
Heart Valves _____		
Hemorrhoids		

	Self	Family
Hepatitis A, B. C		
Hysterectomy		
HIV/AIDS		
Hypothyroidism/Hashimoto's		
High Blood Pressure		
Hyperthyroidism/Graves/Goiter		
High Cholesterol		
Immune System- Weak		
Irritable Bowel Syndrome		
Kidney Disease/Infection _____		
Lung Disease _____		
Lupus		
Lumbar Disc Disease		
Mental Illness _____		
Multiple Sclerosis		
MI /Heart Attack		

	Self	Family
Osteoporosis/Osteopenia Where? _____		
Pelvic Inflammatory Disease		
Rheumatic Fever/Arthritis		
Renal/Kidney Stones		
Seizures/Epilepsy		
Sexually Transmitted Infections		
Shingles		
Skin Disorder _____		
Sleep Disorder/Apnea		
Spinal Cord Injury (Level) _____		
Stroke/TIA		
Stomach Ulcers		
Tuberculosis		
Varicose Veins		
Other:		

REVIEW OF SYSTEMS: Circle all that you have experienced recently or in the past 6 months

Constitutional Chills Fever Weight Gain/Loss Loss of Appetite Fatigue Sleep Disturbance Feeling Unwell (Malaise)	**Cardiovascular** Chest Pain Palpitations Irregular Heartbeat Fast Heartbeat Slow Heartbeat Murmur	**Respiratory** Cough Shortness of Breath Wheezing Asthma Use of Inhaler	**Gastrointestinal** Reflux Indigestion Abdominal Pain Constipation Diarrhea Nausea/Vomiting Change in Stools Blood in Stools Bloating Stool Loss	**Endocrine** Increased Thirst Excessive Hunger Cold Intolerance Heat Intolerance Changes in Blood Sugars: Diabetes Hypoglycemia	**Vascular/Hematologic** Easy Bleeding Easy Bruising Blood Thinners Swelling in limbs Cramping Cold Hands/Feet	**Ears/Nose/Throat** Dry Mouth Difficulty Swallowing Hearing Loss Ringing in ears Sinus Trouble Sore Throat Loss of Taste Denture Use Allergic Symptoms	**Eyes** Blurred Vision Double Vision Glasses/Contacts Eye Pain Watery eyes Itchy Eyes **Head** Lightheadedness Dizziness Headaches Migraines
Musculoskeletal Joint Pain Back/Neck Pain Muscle Aches Muscle Cramps Muscle Weakness Tight Muscles Joint Swelling Fall/Trauma Difficulty Walking Difficulty Lifting/Carrying Use of Cane/Walker Leg/Arm Swelling Osteoporosis Decreased exercise tolerance	**Neurologic** Weakness Impaired Balance Headache Migraines Confusion Numbness Tingling Memory Loss Brain Fog Learning Disabilities	**Skin** Rash/Itching Increased Hair Growth Hair Loss Acne Eczema Dry Skin Flushing of Face Moles Hives	**Genitourinary** Feeling of: Vaginal Bulge Vaginal Laxity Vaginal Dryness Vaginal Itching Vaginal Discharge Vaginal Mass/Lump Vaginal Pain	**Urinary Tract** Frequent Urination Urgency Loss of Urine Frequent Bladder Infections Burning with Urination Blood in Urine Discolored Urine Leakage	**Emotional** Anxiety Panic Attacks Depression Irritability **Immunologic** Food Allergies Seasonal allergies Frequent Illnesses/Colds Immunosuppressed Autoimmune Disease Chemotherapy	**Sexual/Hormone Balance** Lack of Desire Problems with Orgasm Relationship Issues Pain with Intercourse Hot Flashes Night Sweats Mood Swings Weight Problems	**Breast** Pain Nipple Discharge Mass Implants

Therapist Signature Date

Patient Signature Date