red lotus
HEALTH

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention, which is not included on this form, please note it in the Comments section or speak to us about it. Thank you.

Name:_____Home Phone:_____Cell Phone:_____

Address:_____

City:_____State:_____Zip:_____ Job Title:_____

Email address:_____Email is used for appt reminders and newsletters only.

Date of Birth: _____Height:_____Weight:_____Marital Status:_____

Emergency Contact Name:_____Emergency Contact Phone:_____

Referred By:_____Family Physician:_____

What is the main problem (s) you would like help with today? (List in order of importance)

1._____

2._____

3._____

When did this problem begin? (please be specific)

1._____2._____3._____

What was the cause of this problem: _____

_____

What makes it better: (hot, cold, massage, etc.)_____

_____

What makes it worse: (activity, weather, AM, PM) _____

_____

What kind of treatment have you tried?_____

_____

What treatment has been helpful?_____

Is your current condition getting: _____better _____worse _____comes & goes _____same

What is the level of pain or intensity on a scale of 1-10 (10 worst, 0 none):_____

What % of day do you experience relief if any?_____

Current Medication and Supplements: _____

_____

_____

Significant Trauma Incidents or Surgery (auto accidents, falls, hitting head, broken bones, etc.) *Please include dates*:

_____

_____

Do you have a regular exercise program? If so, please describe: _____

_____

Please describe your average daily diet: Morning:_____

Afternoon:_____Evening:_____

How many cigarettes do you smoke a day?_____ How much coffee/tea or cola do you drink per day?_____

How much alcohol do you drink per week? _____ How much nicotine do you chew per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please check any symptoms you have had in the last three months

GENERAL

- ❑ Chills
- ❑ Fevers
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot)
- ❑ No thirst
- ❑ Fatigue
- ❑ Sudden Energy drop
- ❑ Edema
- ❑ Poor sleeping
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Weight gain
- ❑ Weight loss

SKIN AND HAIR

- ❑ Rashes
- ❑ Itching
- ❑ Ulcerations
- ❑ Eczema
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff

FACE, EARS, EYES, NOSE & THROAT

- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
- ❑ Glasses
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Dry eyes
- ❑ Blind spot(s)
- ❑ Spots in front of eyes
- ❑ Eye pain
- ❑ Cataracts
- ❑ Excessive tearing
- ❑ Discharge from eyes
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Earache
- ❑ Ear discharge
- ❑ Grinding teeth
- ❑ Jaw clicks
- ❑ Jaw tension
- ❑ Teeth problems
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Sores on lips or tongue
- ❑ Hoarseness
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Facial pain

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Chest pain/discomfort
- ❑ Cold hands or feet
- ❑ Swelling in hands or feet
- ❑ Blood clots
- ❑ Phlebitis
- ❑ Fainting
- ❑ Difficulty breathing

RESPIRATORY

- ❑ Cough
- ❑ Asthma/Wheezing
- ❑ Pain with deep breath
- ❑ Asthma
- ❑ Difficulty breathing when lying down
- ❑ Production of phlegm
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Bronchitis

GASTRO-INTESTINAL

- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Belching
- ❑ Ulcers
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Laxative use
- ❑ Gas
- ❑ Rectal pain
- ❑ Hemorrhoids

GENITO-URINARY

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Blood in urine
- ❑ Incomplete urination
- ❑ Dribbling
- ❑ Decrease in flow
- ❑ Kidney stones
- ❑ Impotency
- ❑ Sores on genitals
- ❑ Pain with intercourse
- ❑ Change in sexual drive
- ❑ Waking at night to urinate
- ❑ How often_____
- ❑ Peculiar color
- ❑ Particular odor

PREGNANCY & GYNECOLOGY

Number of pregnancies_____
Number of births_____
Number or premature births_____
Number of miscarriages_____
Number of abortions_____
Number of ectopic pregnancies_____
Age at first menses_____
How many days between menses_____
Duration of menses_____
Date of last menses_____

- ❑ Heavy periods
- ❑ Light periods
- ❑ Painful periods
- ❑ PMS
- ❑ Clots
- ❑ Menopause
- ❑ Breast lumps
- ❑ Nipple discharge

Last PAP_____

- ❑ Birth control

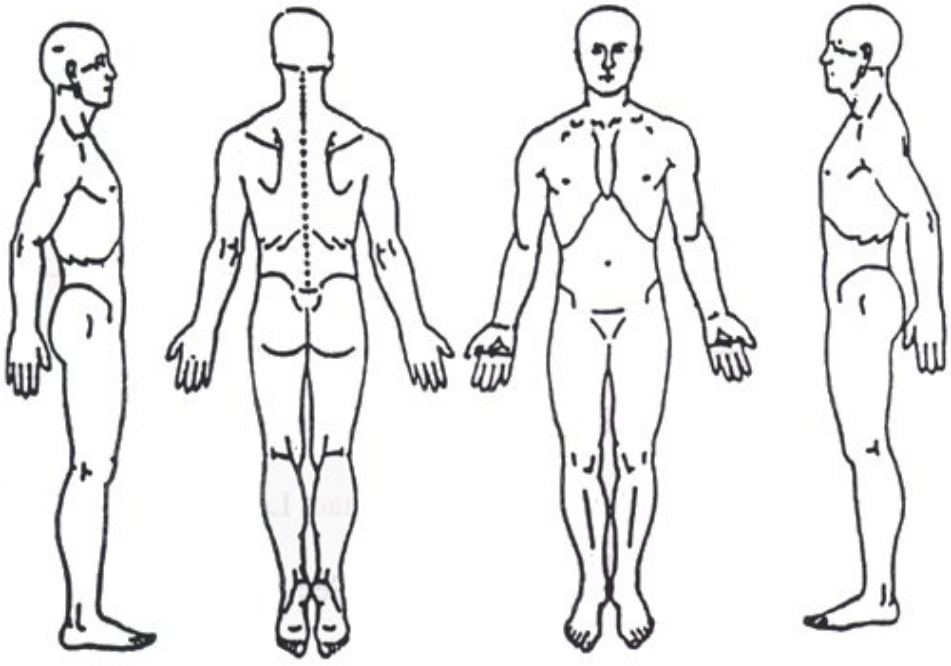
Type_____
How long_____

MUSCULO-SKELETAL

- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Mid-back pain
- ❑ Spinal pain
- ❑ Elbow pain
- ❑ Hand/wrist pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Muscle pain
- ❑ Muscle weakness

NEURO-PSYCHOLOGICAL

- ❑ Seizures
- ❑ Numbness
- ❑ Weakness
- ❑ Sleep problems/disorder
- ❑ Bad dreams
- ❑ Concussion
- ❑ Bad temper
- ❑ Mood swings
- ❑ S.A.D.
- ❑ Violent potential
- ❑ Vertigo
- ❑ Loss of balance
- ❑ Lack of coordination
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse
- ❑ Ever treated for emotional problems
- ❑ Ever attempted or considered suicide



Please mark the body diagrams with the following letters to indicate what you have been experiencing:

P=Pain, T=Tighntess, N=Numbness/Tingling, W=Weakness.

Next to the letter write a number 0 (No Pain) to 10 (Extreme Pain) conveying the intensity of your experience.