A Total Approach to Health and Wellness

HEALTH HISTORY

(Please answer all questions, even if they seem unrelated to your case.)

Name: ______________________________ AHC# __________________________ Date: _________________

Ph: (H) _______________________ (W) ________________________(C) __________________________

(Check your preferred phone number above.)

Address: ____ Postal Code: _____________

Birthdate: _________________ Age: _____ Wt: _____ Ht: _____ Children: ___ Birthplace: _______________

(dd/mm/yyyy)

Sex: Male Female Family MD: ____

Occupation: _________________________________Employer: _______________________________________

Healthcare insurance? (London Life, Blue Cross, etc.) ____

E-Mail Address: ________________________ Check if you want to receive any of the following through e-mail:

Appointment Reminders Health Newsletters Special Offers Special Events

How did you find out about us?

Healthcare Provider	Lawyer	Employer	Clinic Materials
Special Event	Here Before	Website	Special Offer
Can Pages	Yellow Pages	Family/Friends	Signage

Who referred you? ____

Present Complaint: ____

When did this condition begin? ____

What caused this condition? ____

Are there others in your family with this condition? ____

Is this work related? Or a motor vehicle accident? Date of injury/accident? _______________________

Are you here for treatment due to: Surgery? Fracture? Date of occurrence? _____________________

Please complete the following chart:

Prescription Medication	**Over the Counter Medication** (e.g. Tylenol, Advil, etc.)	**Vitamins & Supplements**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Have you been treated for any health condition in the last year? Yes No If yes, list any upcoming/recent tests or surgeries.____

When was the last time you really felt well? ____

(PLEASE COMPLETE THE INFORMATION ON THE OTHER SIDE)

How important is your health to you on a scale of 1 – 10, 10 being most important? ____________________

Provide dates of ALL surgeries, fractures and major illnesses:

____________________ ____________________

____________________ ____________________

List ALL motor vehicle accident dates and other major accidents or falls: (please describe)

____________________ ____________________

____________________ ____________________

Please √ and list any of the following devices that you currently wear or are implanted:

prosthetic devices ____________________ hearing aids orthotics

metal implants ____________________ pacemaker heal lifts/inserts

Check √ any conditions which are **presently** causing you a problem.
Please underline conditions which **were** a problem in the past.

GENERAL
- headache
- migraines
- dizziness
- ringing in ears
- fainting
- earache
- sore throat
- nose bleeds
- sinus problems
- asthma
- enlarged glands
- unexplained weight loss
- hypoglycemia
- nervousness/anxiety
- depression/confusion
- vision problems
- dental problems
- hearing problems
- fever
- night sweats

ORGANS
- frequent urination
- painful urination
- blood in urine
- bladder problems
- kidney stones
- bed wetting
- prostate problems
- sexual dysfunction
- anemia
- eating disorders
- thyroid problems
- excessive appetite
- gas / bloating
- nausea /vomiting
- constipation /diarrhea
- colitis
- black / bloody stool
- hemorrhoids
- liver problems
- gall bladder
- rheumatic fever

SKIN
- eczema
- skin eruptions
- varicose veins
- rashes
- loss of sensation
- varicose veins

MUSCLE & JOINT
- neck problems
- whiplash
- upper back problems
- low back problems
- tailbone pain
- spinal curvature
- pelvic numbness and/or pins & needles
- limb problems
- walking problems
- arthritis
- rheumatoid arthritis
- sore joints
- sore muscles
- jaw problems

RESPIRATIORY & HEART
- lung problems
- chronic cough
- spitting up blood
- frequent colds/flu
- difficult breathing
- heart problems
- swollen ankles

FEMALES ONLY
- painful periods
- irregular cycle
- cramps, backache
- vaginal discharge/infection
- lumps/pain in breast
- menopausal symptoms
- previous miscarriage
- unable to get pregnant
- hot flashes
- Are you pregnant?
  Yes No Not Sure

When was your last period?
____

Check any of the following diseases you have (or have had):

alcoholism HIV hepatitis epilepsy stroke arthritis heart disease

sexually transmitted diseases diabetes cancer allergies other ____________

Has anyone in your family had any of the following diseases?

heart disease	high blood pressure	cancer	stroke	arthritis	diabetes
who ________	who ________	who ________	who ________	who ________	who ________

LIFESTYLE

	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Exercise					Tobacco				
Sleep					Alcohol				
Coffee/Tea					Junk Food				
Pop					Stress				