Health History Questionnaire

Name:_____ **Pt. #:**_____ **Date:**_____

I. Past Medical History

Please take the time to answer the following questions to the best of your ability.

1. Please identify any **current or past medical conditions** that you have been diagnosed with and/or treated for:

Condition		Date Diagnosed
	-	
	-	
	-	
	-	
	-	
	-	

2. Please identify any **surgeries and/or hospitalizations** you have undergone:

Procedure		Date
	-	
	-	
	-	
	-	
	-	
	-	

3. Please identify any **major injuries, traumas, or accidents** you have experienced (beside those in #1 & 2):

Injury/Event		Date
	-	
	-	
	-	
	-	
	-	
	-	

4. Please identify any significant **childhhood diseases and/or illnesses** you have had(beside those in #1,2 & 3):

Disease/Illness		Age
	-	
	-	
	-	
	-	
	-	
	-	

I. Past Medical History (cont.)

6. Circle "Yes" or "No" to indicate if you have had, or currently have, any of the following:

AIDS/HIV	Yes	No	Glaucoma	Yes	No	Pinched Nerve	Yes	No
Anemia	Yes	No	Goiter	Yes	No	Pneumonia	Yes	No
Anorexia	Yes	No	Head Injury	Yes	No	Prostate Disease	Yes	No
Appendicitis	Yes	No	Heart Disease	Yes	No	Prosthesis	Yes	No
Arthritis	Yes	No	Heaving Problems	Yes	No	Psychiatric Care	Yes	No
Atherosclerosis/	Yes	No	Hepatitis	Yes	No	Respiratory Disease	Yes	No
Arteriosclerosis			Hernia	Yes	No	Rheumatoid Arthritis	Yes	No
Asthma	Yes	No	Herniated disk	Yes	No	Stroke	Yes	No
Bleeding Disorders	Yes	No	High Cholesterol	Yes	No	Thyroid Problems	Yes	No
Blood Clots	Yes	No	Hypertension	Yes	No	TMJ syndrome	Yes	No
Breast Lump	Yes	No	Kidney Disease	Yes	No	Tonsillitis	Yes	No
Bowel/Colon Disease	Yes	No	Joint Disease	Yes	No	Tuberculosis	Yes	No
Cancer	Yes	No	Joint Fusion	Yes	No	Tumors, Growths	Yes	No
Car Accident	Yes	No	Ligament Injuries	Yes	No	Ulcers	Yes	No
Cataracts	Yes	No	Liver Disease	Yes	No	Vision Problems	Yes	No
Chemical Dependency	Yes	No	Metabolic Disorders	Yes	No	Vaginal Infections	Yes	No
Circulation Problems	Yes	No	Migraine Headaches	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Miscarriage	Yes	No	Vertigo	Yes	No
Dislocations	Yes	No	Mononucleosis	Yes	No	Whooping Cough	Yes	No
Emphysema	Yes	No	Multiple Sclerosis	Yes	No	Whiplash	Yes	No
Epilepsy	Yes	No	Osteoporosis	Yes	No	Other_____		
Fractures	Yes	No	Pacemaker	Yes	No	_____		
			Parkinson's Disease	Yes	No	_____		

II. Family History

Grandparents Living: (#)_____ Parents Living: (one/both) _____ Siblings: (#) _____

Deaths of above from disease: (identify relationship and cause of death)_____

_____

_____

Diseases or disorders known, or suspected to, run in family:_____

_____

Health problems – Father:_____

Mother:_____

Siblings:_____

Past Medical History (cont.)

III. Current Health History

On a scale of **1 – 10** I would grade my overall health as _____

Number of hours spent at work/in school per week _____

Percentage of above hours spent:

Seated_____ Standing_____ Performing physical duties:_____

Types of regular exercise you engage in: _____

Number of hours per week_____

"Go to" sleeping position: _____front _____side _____back

Have you seen the following healthcare professionals in the last year?

_____Dentist _____Chiropractor _____General Practitioner

_____Specialist, MD (if yes, which one)_____

_____Massage Therapist _____Acupuncturist Others_____

	Needs no Improvement	Needs Improvement	Needs Significant Improvement
I would rate my diet as:	_____	_____	_____

Have you developed a specific personal nutrition plan? _____

Please indicate the influence of stress in your daily life **(circle one)**

0 1 2 3 4 5 6 7 8 9 10

Never Feel Stressed | Stressed 50% of the Time | Always Feel Stressed

Things you do to avoid/reduce stress: _____

Do you use tobacco? Y N Amount per week: _____

Do you use alcohol? Y N Amount per week: _____

Do you use recreational drugs? Y N Amount per week:_____

Are you on any medications? Y N If yes, please list name of drug and condition prescribed for:

_____

_____

Are you currently involved in a healthcare treatment program(s) with another practitioner(s)? Y N

If yes, please identify practitioner and condition being treated for: _____

_____