



# Health Overview

*This form expands on the one you filled out for your first visit and helps us get a more complete understanding of you. Please fill it out as completely as possible, we appreciate the time you spend on it. Mark anything that you do not understand with a question mark. Thank you.*

Education/Degree: \_\_\_\_\_

Relationship status:  Single  Married  Partnership  Separated  Divorced  Widowed

Live with:  Alone  Spouse  Partner  Parents  Children  Friends/Roommate

Employment status:  Full-time  Part-time  School  Retired  Unemployed  Other \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Employer: \_\_\_\_\_ S.S.#: \_\_\_\_\_

What do you consider your most important health issues? List in order of importance:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

6) \_\_\_\_\_

What behaviors do you currently do regularly that you feel support your health? (please list)

What behaviors do you do regularly that you feel hurt your health? (please list)



# Health Overview

What obstacles do you see yourself having in improving your diet and lifestyle?

What obstacles do you see yourself having in following the treatment plans we create for you?

Who do you know that will support you in making the positive lifestyle changes you will be making to improve your health?

## Healthcare Providers

Are you seeing other healthcare providers? (please include their names) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Family History

Member	Age	Important diseases	Living?	Cause of death
Mother				
Father				
Siblings				
Siblings				
*MGM				
*MGF				
*PGM				
*PGF				

M = Maternal (Mother) P = Paternal (Father) GM = Grandmother GF = Grandfather

Any other important family history? \_\_\_\_\_



# Health Overview

What is your ethnic background? \_\_\_\_\_

### Hospitalization, Surgery, Imaging

Have you been in the hospital, had surgery, X-Rays, CAT Scans, EEG, EKG's?

\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_

### Accidents/Injuries (briefly describe)

More than 5 years ago \_\_\_\_\_

Less than 5 year ago \_\_\_\_\_

### Allergies

Do you have allergies or reactions to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Environmental allergies? \_\_\_\_\_

Chemicals? \_\_\_\_\_

To the best of your knowledge have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation or other toxins beyond those encountered in regular, daily life? \_\_\_\_\_

### General

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Weight 1 year ago: \_\_\_\_\_ lbs.

Maximum Weight : \_\_\_\_\_ When: \_\_\_\_\_

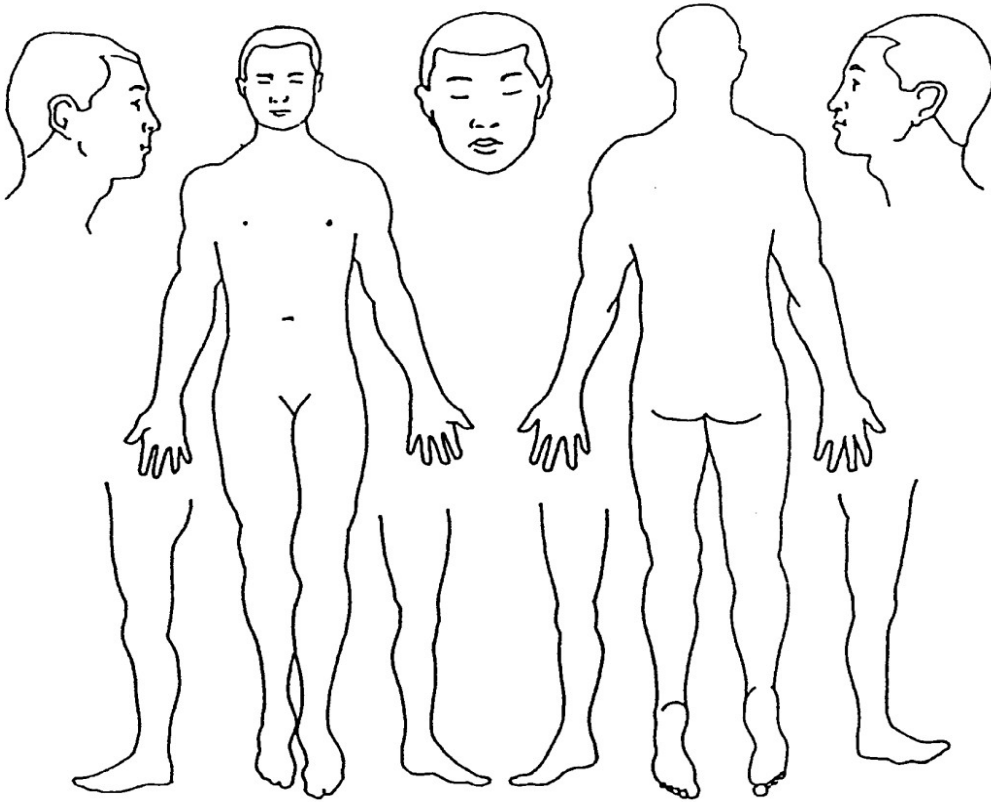
When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

# Health Overview

**PAIN**

DO YOU HAVE ANY PAIN(S)?  Yes  No

Please circle/shade in painful or distressed areas



AREA/DESCRIPTION OF SYMPTOMS

PAIN LEVEL: 0 TO 10  
(10 most painful)

How often

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# Health Overview

## Current Medications

Are you currently using?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Pain medication	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N
Birth control pills	Y N	Immune suppressants	Y N		

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking. Please include the brand and dosage. If you need more room please write on the back of the page or include an attached sheet.

- |          |           |
|----------|-----------|
| 1) _____ | 7) _____  |
| 2) _____ | 8) _____  |
| 3) _____ | 9) _____  |
| 4) _____ | 10) _____ |
| 5) _____ | 11) _____ |
| 6) _____ | 12) _____ |

## Typical Diet

Any dietary preferences/restrictions? \_\_\_\_\_

What is your favorite food? \_\_\_\_\_ Favorite flavor? \_\_\_\_\_

Sample Day's menu (Please fill out a true sample day, and not what you think we want you to put. We do not judge your food choices, our goal is to help eat the foods to best help you)

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_



# Health Overview

## HEAD TO FOOT REVIEW

PLEASE CIRCLE

**Y**=a condition you have now

**N**=Never had

**P**=Significant problem in the past

### Habits

Hobbies? \_\_\_\_\_

Do you exercise?	Y N	If yes, what kind? _____	
How often? _____		Enjoy your work?	Y N
Average amount of sleep per night _____		Take vacations?	Y N
Sleep well?	Y N	Spend time outside?	Y N
Awaken rested?	Y N	Watch TV?	Y N
Have supportive relationships?	Y N	Hours/day _____	
Intimate	Y N Not in	Read?	Y N
Family	Y N	Hours/day _____	
Friends	Y N	Eat 3 meals/day?	Y N
History of abuse?	Y N	Diet often?	Y N
Any major traumas?	Y N	Eat out often?	Y N
Use recreational drugs?	Y N P	Drink coffee	Y N
Drink alcohol?	Y N	Drink cola/soda?	Y N
Drinks/week _____		Eat sugar?	Y N
Been treated for addiction?	Y N		
Smoke tobacco?	Y N P	Always practice safe sex?	Y N
How many years _____			
Packs/day _____			
Do you have a religious or spiritual practice?	Y N	If yes, what? _____	

### Mental / Emotional

Treatment for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P
Seasonal depression?	Y N P	Easily stressed	Y N P



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## Immune

Frequent infections?	Y N P	Negative reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P
Frequent colds	Y N P	Cancer	Y N P
		What type? _____	

## Endocrine

Hypothyroid (low thyroid)?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia (low blood sugar)?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Night sweats	Y N P

## Nerves

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Loss of balance?	Y N P
Vertigo or dizziness?	Y N P		

## Skin

Skin <input type="checkbox"/> Normal <input type="checkbox"/> Dry <input type="checkbox"/> Oily		Rashes?	Y N P
Eczema	Y N P	Hives?	Y N P
Acne?	Y N P	Itching?	Y N P
Color Change?	Y N P	Significant Hair Loss?	Y N P
Lumps?	Y N P		

## Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

## Eyes

Spots in eyes?	Y N P	Cataracts?	Y N P
Poor vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Excessive tearing or dryness?	Y N P
Double vision?	Y N P	Glaucoma?	Y N P





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## Digestive

Trouble swallowing?	Y N P	Heartburn / GERD?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting?	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _____	
Gall bladder stones?	Y N P	Is this a change?	Y N
Liver disease / Hepatitis?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

## Urinary

Pain when urinating?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Unable to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

## Muscles and Bones

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Frequent broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P
Osteoporosis?	Y N	Muscle pain?	Y N P
Growing pains	Y N P		

## Blood / Vessels

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Blood clots?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Stroke / TIA?	Y N P

## Male

Hernias?	Y N P	Testicular masses?	Y N P
Testicle pain?	Y N P	Prostate cancer?	Y N P
Enlarged prostate?	Y N	Prostatitis?	Y N P
Sexually transmitted infections?	Y N P	Discharge or sores?	Y N P
If yes, what? _____		Are you sexually active?	Y N
Sexual orientation: _____		Impotence?	Y N P
Premature ejaculation?	Y N P	Trouble achieving orgasm?	Y N P
Infertility?	Y N P		



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## Female

Age at first period? \_\_\_\_\_  
 Age at last period? (if menopausal) \_\_\_\_\_  
 Length of cycle? \_\_\_\_\_ days  
 Length of period? \_\_\_\_\_ days  
 Painful periods?                    Y N P  
 Heavy or excessive flow?        Y N P  
 PMS?                                    Y N P  
 If yes, what are your symptoms?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Endometriosis?                    Y N P  
 Ovarian cysts?                    Y N P  
 Difficulty conceiving?           Y N P  
 Cervical dysplasia?              Y N P  
 Sexually transmitted infections? Y N P  
   If yes, what? \_\_\_\_\_  
 Sexual orientation: \_\_\_\_\_  
 Breast lumps?                      Y N P  
 Nipple discharge?                Y N P

Date of last annual exam/ PAP \_\_\_\_\_  
 Are your cycles regular?            Y N  
 Bleeding between cycles?        Y N P  
 Pain during sex?                    Y N P  
 Clots in period blood?            Y N P  
 Discharge?                         Y N P  
 Birth control?                      Y N P  
   What type? \_\_\_\_\_  
 Number of pregnancies: \_\_\_\_\_  
   Number of live births: \_\_\_\_\_  
   Number of miscarriages: \_\_\_\_\_  
   Number of abortions: \_\_\_\_\_  
 Menopausal symptoms?            Y N P  
 Abnormal PAP?                    Y N P  
 Trouble achieving orgasm?        Y N P  
 Are you sexually active?           Y N  
 Do you do breast self exams?      Y N P  
 Breast pain/tenderness?          Y N P  
 Mammograms?                      Y N P

Please use the back of the sheet or an additional page to add any other information about yourself that you think will be of help to us

**Done. Thank you for your time and effort.**