# FORM HEALTH

## NEW PATIENT PERSONAL HEALTH HISTORY

Full Name: _____ Date of Birth: _____ Today's Date: _____

**Primary reason for visit today**: _____ Date of onset: _____

Other practitioners or clinics seen for primary complaint: _____

_____

Additional areas of concern (List secondary complaints or other conditions. Note: additional visit(s) may be required to adequately address complex or multiple issues):

2. _____ Date of onset: _____

3. _____ Date of onset: _____

*The following questions, up until the General Health Overview, are only necessary for primary complaints related to pain, injury, or physical conditions.*

Type of injury/complaint (check all that apply):

☐ New/Recent ☐ Recurring/Chronic ☐ Sports/Exercise related ☐ Work related

☐ Trauma ☐ Overuse ☐ Motor Vehicle Accident ☐ Other _____

Brief description of how the injury occurred: _____

Average Pain level through the day (0=none, 10=severe): ____/10 At night: ____/10 At worst: ____/10

Do you experience weakness, numbness or tingling? ☐ Yes ☐ No If yes, where?_____

Do you experience pain that radiates or travels? ☐ Yes ☐ No If yes, where?_____

What type of imaging have you had for the *current complaint*?

☐ Xray ☐ MRI ☐ Ultrasound ☐ CT ☐ None ☐ Other

What other treatments or care have you tried?

☐ Pain Medications ☐ Muscle Relaxers ☐ NSAIDs (anti-inflammatories) ☐ Other Meds/Supplements

☐ Massage ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture

☐ Surgery ☐ Steroid injection ☐ Regenerative injection ☐ Other_____

## General Health Overview

Who is your primary care physician? _____

For what concern did you last receive medical care?_____

Approximately when did you last have bloodwork or labs done? ☐ within 3 months ☐ within 1 year ☐ over 1 year

Do you have any known contagious diseases at this time? ☐ Yes ☐ No If yes, what?_____

Have you had any negative reactions to immunizations? ☐ Yes ☐ No

**Name**: _____

Indicate if YOU have, or have had, any of the following conditions:

| | | | | |
|---|---|---|---|---|
| ☐ Cancer | ☐ Heart Disease | ☐ Anemia | ☐ Allergies | ☐ Arthritis |
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Kidney Disease | ☐ Asthma | ☐ Tuberculosis |
| ☐ Epilepsy | ☐ Stroke | ☐ Glaucoma | ☐ Mental Illness | ☐ Appendicitis |
| ☐ Blood Clots | ☐ Bleeding Disorders | ☐ Gallbladder disease | ☐ Concussion or Traumatic Brain Injury | |

Indicate if any FAMILY (sibling, parents, grandparents) has or has had any of the following conditions:

| | | | | |
|---|---|---|---|---|
| ☐ Cancer | ☐ Heart Disease | ☐ Anemia | ☐ Allergies | ☐ Arthritis |
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Kidney Disease | ☐ Asthma | ☐ Tuberculosis |
| ☐ Epilepsy | ☐ Stroke | ☐ Glaucoma | ☐ Mental Illness | ☐ Appendicitis |
| ☐ Blood Clots | ☐ Bleeding Disorders | ☐ Gallbladder disease | ☐ Concussion or Traumatic Brain Injury | |

Please list any hospitalizations, surgeries, imaging or special studies you have had:

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Please list any significant scars and their locations: _____

Height: ___ ft. ___ in. Weight: _____ lbs. Maximum Weight:_____lbs. When? _____

## Medications and Allergies

**If needing more space, please provide complete list or write on back*

| **Medications** | Dose (ie 100mg) | Frequency (ie 2x/day) | Approx time on med |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| **Supplements** | Dose (ie 100mg) | Frequency (ie 2x/day) | Approx time on med |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| **Allergies** (Drug, Food, and/or Environmental) | Reaction (e.g. rash, hives, anaphylaxis, etc) |
|---|---|
| ☐ Check here if you have *No Known Allergies*. | |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Name: _____

# Lifestyle Habits

**Daily Routines** (select all that apply)

☐ Average 6-8hrs sleep/night ☐ Have a supportive relationship ☐ Enjoy your work ☐ Drink cola or soda
☐ History of major trauma ☐ History of physical abuse ☐ History of mental or emotional abuse

**Exercise** (select all that apply)

☐ Walking ☐ Running ☐ Lifting weights ☐ Team Sports ☐ Racquet sports
☐ Yoga ☐ Barre3 or Pilates ☐ Aerobic Classes ☐ CrossFit or HIIT ☐ Rock Climbing
☐ Hiking ☐ Surf / SUP ☐ Other ☐ Can't exercise due to pain/condition ☐ Don't typically exercise

**Exercise Frequency**

☐ Never ☐ Less than 1x/week ☐ 1-2x/week ☐ 3-6x/week ☐ Daily

**Alcohol use** (average intake)

☐ Don't drink / Less than 1x/month ☐ Less than 1x/week ☐ 1-5 drinks/week
☐ 1-2 drinks/day ☐ more than 2 drinks/day ☐ Don't currently, treated for alcoholism

**Smoking status**

☐ Never smoked ☐ past smoker ☐ Current, non-daily ☐ Current, <1 pack/day ☐ Current, 1+ pack/day

**Recreational drug use** (select all that apply)

☐ Current Marijuana ☐ Current cocaine ☐ Current Meth or heroin ☐ Other IV Drug use
☐ Past Marijuana ☐ Past cocaine ☐ Past Meth or heroin ☐ Never used recreational drugs

# Review of Symptoms

*Check any you have, or have had, in the last 6 months*

**Skin**

☐ Rashes ☐ Eczema, Hives ☐ Acne, Boils ☐ Itching ☐ Fungal Infections
☐ Hair Loss ☐ Dry skin/scalp ☐ Lumps ☐ Slow healing ☐ Others

**Head/Neck**

☐ Headache ☐ Migraine ☐ Lightheadness ☐ Dizziness ☐ Jaw pain
☐ Goiter ☐ Swollen Glands ☐ Pain or stiffness ☐ Others

**Muscles/Joints/Bones**

☐ Joint Pain ☐ Muscle Pain ☐ Spasms/Cramps ☐ Restless Legs ☐ Sciatica
☐ Tendonitis ☐ Unstable joints ☐ Broken bones ☐ Torn tendons ☐ Others

**Nose and Sinuses**

☐ Nose bleeds ☐ Frequent colds ☐ Stuffiness ☐ Hay Fever ☐ Jaw pain
☐ Loss of smell ☐ Sinus problems ☐ Others

**Respiratory/Lungs**

☐ Wheezing ☐ Chest congestion ☐ Asthma ☐ Difficulty breathing ☐ Cough
☐ Cough blood ☐ Shortness of breath ☐ Allergies ☐ Sleep Apnea ☐ Others

**Immune**

☐ Swollen glands ☐ Chronic infections ☐ Slow wound healing ☐ Others

Name: _____

**Neurologic**

☐ Seizures ☐ Numbness or Tingling ☐ Paralysis ☐ Muscle weakness ☐ Loss of balance
☐ Vertigo ☐ Sensitivity to touch ☐ Others

**Mouth and Throat**

☐ Sore throat ☐ Excess Saliva ☐ Teeth grinding ☐ Sore tongue/lips ☐ Gum problems
☐ Hoarseness ☐ Loss of taste ☐ Others

**Eyes and Ears**

☐ Itchy eyes ☐ Watery eyes ☐ Dry eyes ☐ Red eyes ☐ Blurry vision
☐ Vison loss ☐ Floaters in vision ☐ Cataracts ☐ Color blindness ☐ Glaucoma
☐ Ears ringing ☐ Difficulty hearing ☐ Earaches ☐ Ear Infection ☐ Others

**Cardiovascular/Heart**

☐ Heart disease ☐ Angina/Chest pain ☐ High blood pressure ☐ Low blood pressure ☐ Murmurs
☐ Blood clots ☐ Palpitation/flutters ☐ Irregular heart beat ☐ Swelling in ankles ☐ Others

**Circulation**

☐ Easy bruising ☐ Deep leg pain ☐ Varicose veins ☐ Anemia ☐ Others

**Endocrine/Hormones**

☐ Hypothyroid ☐ Hyperthyroid ☐ Hypoglycemia ☐ Diabetes ☐ Excess thirst
☐ Night sweats ☐ Seasonal depression ☐ Hot flashes ☐ Hot/cold intolerance ☐ Others

**Digestion**

☐ Ulcer ☐ Trouble swallowing ☐ Nausea/vomiting ☐ Gas/bloating ☐ Diarrhea
☐ Constipation ☐ Heartburn/acid reflux ☐ Pain or cramps ☐ Hemorrhoids ☐ Itchy anus
☐ Rectal pain ☐ Mucus in stools ☐ Bloody stools ☐ Jaundice ☐ Others

**Urinary**

☐ Kidney stones ☐ Painful urination ☐ Infections ☐ Blood in urine ☐ Incontinence
☐ Frequent urination ☐ Interstitial cystitis ☐ Others

**Mental/Emotional**

☐ Mood swings ☐ Anxiety or Nervousness ☐ Depression ☐ Poor Concentration
☐ Poor Memory ☐ Considered/Attempted suicide ☐ Others

**General**

☐ Cravings ☐ Poor sleep/Insomnia ☐ Chills or Fever ☐ Low Libido ☐ Night sweats
☐ Hot flashes ☐ Experience high stress ☐ Chronic fatigue ☐ Others

**Are you currently sexually active?** ☐ Yes ☐ No

**Birth Control type**

☐ None ☐ Condoms ☐ IUD ☐ Birth control pill ☐ Implant
☐ Surgical (Hysterectomy / Vasectomy ☐ Others

**FEMALE specific**

☐ PMS symptoms ☐ Heavy menstruation ☐ Endometriosis ☐ Ovarian cysts
☐ Fibroids ☐ Difficult or painful periods ☐ Others

**Name**: _____

**FEMALE specific** (continued)

| | | | |
|---|---|---|---|
| Age menses began | _____ | Number of pregnancies | _____ |
| Age of last menses (if menopausal) | _____ | Number of live births | _____ |
| Cycle Length (Day 1 to Day 1) | _____ | Number of difficult or surgical births | _____ |
| Duration of Flow (# of days) | _____ | Number of miscarriages | _____ |
| Date of last period | _____ | Number of abortions | _____ |
| Date of last Pap smear | _____ | Do you do self breast exams | ☐ Yes ☐ No |
| Date of last mammogram | _____ | Could you be pregnant? | ☐ Yes ☐ No |

## Context of Care Overview

We would like to take this moment to welcome you to our practice. We look forward to our role in providing you with a long-term comprehensive health solution. Below are a few questions that would assist us in understanding how we can best support your health goals.

1) How did you discover our clinic and how did you decide to see us now?

2) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

   0% 0 1 2 3 4 5 6 7 8 9 10 100%

   If you answered less than "10", what stands between your current commitment and 100%?

3) What behaviors or lifestyle habits do you engage in regularly that you believe support your health?

4) What behaviors do you currently engage in regularly that you believe are self-destructive?

5) What are your top three expectations of us?

   1. 2. 3.