INTEGRATED HOLISTIC HEALTHCARE

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Please fill out this **confidential** health history form as completely as you can. The more information you provide us, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask for help. Unless we sincerely feel that your condition responds satisfactorily to treatment, we will not recommend treatment.

Patient Information

Patient's Last Name		First		Middle	Today's Date
Address		City		State	Zip
Home Phone		Cell Phone		E-mail Address	
Age	Birth Date	Sex	Marital Status	# of Children	Who referred you to the doctor?
Occupation		Employer	Address		Business Phone
Parents/Guardians if minor					
Is Medicare your primary insurance? Yes/No		If Yes Medicare #			
In case of emergency notify			Relationship		Phone #
Family Doctor			May we contact him/her about your health? Yes/No		Phone #
Person Responsible for Payment			Address		Phone #

Check Boxes Below.

Have you ever -	Yes	No	If yes, when and for what condition.
Had a broken bone?			
Had strains or sprains?			
Used a cane, crutch or other support?			
Been struck unconscious?			
Been hospitalized for surgery/injury?			
Been hospitalized for anything other than surgery/injury?			
Do you -	Yes	No	(list fully later)
Take minerals/ herbs/ vitamins?			
Think you need minerals/ herbs/ vitamins?			
Have any drug allergies?			
Do you have any other allergies?			

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Health Concerns or conditions*:*		
How long have you had condition?	Is it getting worse?	Does it bother your Work? Sleep? Other /specify
What seemed to be the initial cause?		
How often does this problem currently bother you?		
Does anyone else in your family/friend group have the same or similar problem? Yes / No Whom?		

What **treatments** have you already received for this condition?

☐ None ☐Medications ☐Nutritional Support ☐Surgery
☐ Chiropractic ☐Physical Therapy ☐Counseling ☐Injection/s
☐Other:_____

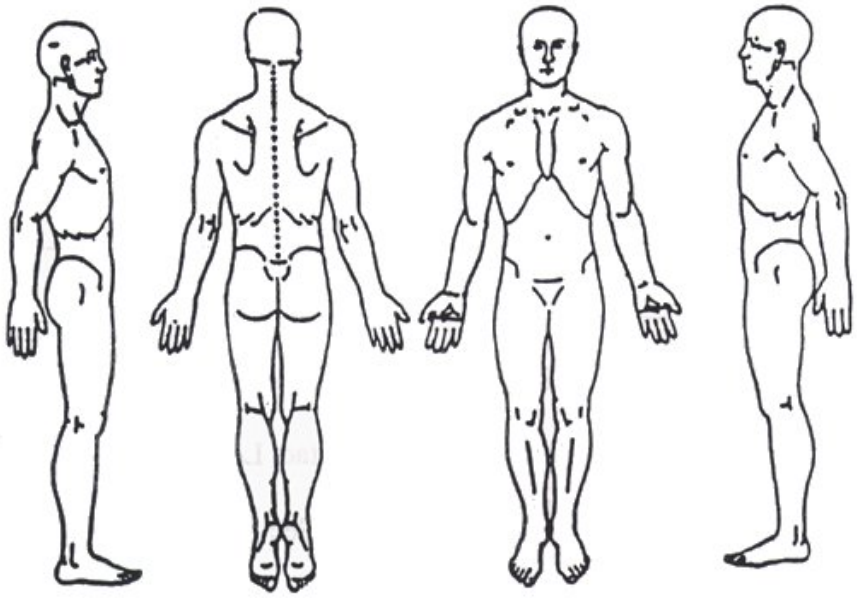
Name of other **practitioner(s)** who have treated this condition _____

_____

Have you become discouraged that this problem has not been resolved? Yes / No

On a scale of 1-10 (10 highest) rate your commitment to getting rid of this problem: _____

Please circle any areas of pain/discomfort in your body



Circle any quality of the pain you are experiencing:

Pain / Stabbing / Aching / Burning / Numbness / Pins & Needles / Other:_____

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IMPORTANT: Please put an X to the right of any condition you have had any time in your life, and CIRCLE the name of the condition if you have had this issue in the past few months

Muscle/Joint	X	Eye-Ear-Nose-Throat	X	Skin	X	Other Conditions	X
Arthritis		Asthma		Boils		Alcoholism	
Bursitis		Blurred Vision		Bruise Easily		Anemia	
Foot Trouble		Colds		Dryness		Appendicitis	
Hernia		Crossed Eyes		Hives or Allergy		Arteriosclerosis	
Low Back Pain		Deafness		Itching		Cancer	
Mid-Back Pain		Dental Decay		Skin Eruptions (rash)		Chicken Pox	
Lumbago		Double Vision		Tattoos		Chorea	
Neck Pain, Stiffness		Earache/Infection		Varicose Veins		Cold Sores	
Morning Stiffness		Ear Discharge		**Pain/Numbness in:**		Diabetes	
Muscle Aches		Ear Noise		Shoulders		Diphtheria	
Pain Between Shoulders		Enlarged Glands		Arms		Eczema	
Sore after exercise		Enlarged Thyroid		Elbows		Edema	
Trouble w/stairs		Eye Pain		Hands		Emphysema	
Trouble w/walking		Failing Vision		Hips		Epilepsy	
General		Far Sightedness		Legs		Fever Blisters	
Allergy		Flu		Knees		Goiter	
Chills		Gum Trouble		Feet		Gout	
Convulsions		Hay Fever		Painful Tailbone		Heart Disease	
Depression		Hoarseness		Poor Posture		Herpes	
Dizziness		Infected Piercings		Sciatica		Influenza	
Fainting		Nasal Obstruction		Spinal Curvature		Lumbago	
Fatigue		Near Sightedness		Swollen Joints		Malaria	
Fever		Nose Bleeds		**Respiratory**		Measles	
Headache		Red Ears		Chronic Cough		Miscarriage	
Insomnia		Ringing in Ears		Collapsed lung		Multiple Sclerosis	
Loss of Sleep		Sinus Infection/Pain		Difficult Breathing		Mumps	
Loss of Weight		Sore Throat		Spitting up Blood		Pacemaker	
Migraine		Tonsillitis		Spitting up Phlegm		Pleurisy	
Nervousness/Anxiety		**Gastrointestinal**		Wheezing		Pneumonia	
Neuralgia		Belching or gas		**WOMEN Only**		Polio	
Numbness		Colitis		Breast Pain		Rheumatic Fever	
Sweats		Colon Trouble		Congested Breasts		Scarlet Fever	
Tremors		Crohn's Disease		Cramps or Backache		Small pox	
Weight gain		Constipation		Currently Sexually Active		Stroke	
Cardiovascular		Diarrhea		Dry Vaginal Canal		Thyroid Disorder	
Ankle Swelling		Difficult Digestion		Endometriosis		Tuberculosis	
Bloody Nose		Bloated Abdomen		Excess Menstrual Flow		Typhoid Fever	
Chest Pain/Angina		Blood in Stool		Fibroids (Uterine/Ovarian)		Ulcers	
Hardening of Arteries		Excessive Hunger		Hot Flashes		Venereal Disease	
High Blood Pressure		Gallbladder Trouble		Irregular Cycle		Whooping Cough	
Low Blood Pressure		Heartburn/GERD		Lumps in Breast		**Genitourinary**	
Pain Over Heart		Hemorrhoids		Menopause		Bed-wetting	
Palpitations		Intestinal Worms		Painful Menstruation/PMS		Bladder Infection	
Poor Circulation		Irritable Bowel Syndr.		Vaginal Discharge		Blood In Urine	
Rapid Heartbeat		Jaundice		Vaginal Infection		Discolored Urine	
Slow Heartbeat		Liver Trouble		Vaginal Pain		Frequent Urination	
Swelling of Ankles		Nausea				Kidney Stones	
MEN ONLY		Pain Over Stomach		Are you Pregnant?		Lack of Kidney Control	
Currently Sexually Active		Poor Appetite		If yes, how many mos. _____		Kidney Infection	
Erectile Dysfunction		Skipping meals		Number of Children:		Painful Urination	
Loss of Libido		Ulcerative Colitis				Prostrate Trouble	
Prostate Dysfunction		Vomiting/Vomit Blood		# of Miscarriages: _____		Pus in Urine	

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MEDICATION/SUPPLEMENTS

Name Dosage Date started Reason

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

attach more as needed

HEALTH SCREENING HISTORY

List the date/year of your most recent test or exam.

Mammogram:_____ Thermogram:_____ Pap Smear:_____ Breast Exam by Doctor:_____

OBGYN/Pelvic Exam:_____ Blood test (what for):_____

Prostate/Rectal Exam:_____ Self Testicle Exam:_____ Testicle Exam by Professional:_____

Test for Blood in stool:_____ Colonoscopy:_____

Immunizations: Polio:_____ Tetanus:_____ Hepatitis:_____ Pneumonia:_____ Flu Shot:_____

Physical Exam:_____ X-Ray:_____

Chiropractic treatment: _____ Acupuncture treatment:_____ Physical Therapy:_____

Are you under the care of a physician? If yes, for what? _____

Do you have any other health conditions you have been treated for in the past 10 years? (list below)

_____

_____

_____

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Check Boxes Below

Habits	**None**	**Light**	**Mod.**	**Heavy**	**Comments if any.**
Alcohol					
Coffee					
Tea					
Soda					
Tobacco					
Medication Drugs					
Recreational Drugs					
Exercise					
Sleep					
Appetite					
Soft Drinks					
Water					
Salty Foods					
Fried Foods					
Milk					
Cheese					
Gluten					
Grains					
Corn					
Soy					
Refined White Sugar					
Natural Sugars- honey, maple syrup, etc.					
Artificial Sweeteners- Stevia, Truvia, Splenda, Equal, SweetNlow, xylitol					

What is your **energy** level on a scale from 0-10 (10 being highest): _____ / 10

What do you remember most?
☐ What you **SEE** ☐ What you **HEAR** ☐ What you **FEEL/TOUCH/INTERACT WITH**

The main reason I brush my teeth is to:
☐ Avoid tooth decay and gum disease ☐ Have healthy teeth and gums

When I make ***decisions*** I generally:
☐ Gather facts and weigh the evidence ☐ Decide quickly on a best choice
☐ Consult my friends and family ☐ Base decisions upon how I *feel* about it

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SENSITIVE HEALTH INFORMATION

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your case. Please complete as accurately as possible.

History of smoking cigarettes, cigars, or chew tobacco? Yes / No
If yes, how much? _____ For how many years? _____

History of alcohol use? Yes / No If yes, what kind/s? _____
If yes, how much? _____ For how many years? _____

History of recreational drug use? Yes / No If yes, what kind/s? _____
If yes, how much? _____ For how many years? _____

Have you been diagnosed with a mental illness? Yes / No Diagnosis: _____
If yes, treatment? _____

Have you ever been tested for the HIV virus? Yes / No Results? _____

Have you ever been diagnoses with HIV or an HIV related illness? Yes / No
If yes, what type of treatment are you under, if any? _____

When is the last time you were tested for any STD's? _____ Results? _____
If so, when/what was the treatment? _____

MENTAL/EMOTIONAL HEALTH HISTORY

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could possibly imagine and 1 being relatively no stress.

Please circle the appropriate number:	Low									High
Financial/Money Matters	1	2	3	4	5	6	7	8	9	10
Relationship/Family	1	2	3	4	5	6	7	8	9	10
Job/Career/Education	1	2	3	4	5	6	7	8	9	10
Current level of health	1	2	3	4	5	6	7	8	9	10
Spiritual/Religious	1	2	3	4	5	6	7	8	9	10
Ethical/Moral	1	2	3	4	5	6	7	8	9	10
Overall level of life stress	1	2	3	4	5	6	7	8	9	10

Please check all of the following life events that you currently (or previously) experience stress with:

- ☐ Birth of siblings
- ☐ Toilet training
- ☐ Babysitters
- ☐ Death of a pet/pet health
- ☐ School
- ☐ Teachers
- ☐ Friends
- ☐ Colleagues
- ☐ Fights
- ☐ Onset of puberty
- ☐ Romance
- ☐ Illness/operations
- ☐ Parental conflict/separation
- ☐ Divorce
- ☐ Dating
- ☐ College
- ☐ Abortion/Miscarriages
- ☐ Infertility
- ☐ Any betrayal
- ☐ Marriage
- ☐ Moving
- ☐ Traveling
- ☐ Accidents
- ☐ Loss of job/layoff
- ☐ Financial disruptions
- ☐ Illness of a loved one
- ☐ Diagnosis of a fatal condition
- ☐ Death of a loved one
- ☐ Other: _____