Health History Form

Date: __________

Patient Name ______________________________ Birth Date _________

Address: __________________________________ Height: __________

____ Weight: __________

Occupation: ________________________________ Gender: M or F

Patient Phone Number: ______________________

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1. Education: (Last grade completed) _____________________________________
2. Significant birth events ____
3. Injuries ____
4. Surgeries ____
5. Pregnancies ____
6. Allergies to ragweed pollen, grasses? ___________________________________
7. Food or Chemical Sensitivities? ____
8. Present Medications ____

   ____
9. Previous Medications ____

   ____
10. Primary Diagnosis ____
11. Present Treatment Approach ____

    ____

11. Please describe your diet _____

_____

_____

12. What are some of your favorite foods? _____

13. Do you often get sleepy after meals? Yes _____ No _____

14. Sleep problems? _____

15. Do you usually recall dreams? _____

16. Do you smoke cigarettes? _____ How many daily? _____

17. Do you drink alcohol? _____ How frequently? _____

18. Did you enjoy school? Yes _____, No _____

19. Typical grades in school: A B C D F

20. Favorite subjects _____

21. Difficult subjects _____

22. Tendency for Anger: High _____ Average _____ Low _____

23. Tendency for Anxiety: High _____ Average _____ Low _____

24. Hobbies? _____ Sports? _____

25. Do you experience depression? Often ____ Sometimes ____ Never _____

26. Pain threshhold: High _____ Average _____ Low _____

27. Do you function well under stress? Yes _____ No _____

28. Are you competitive at sports? Very _____ Average _____ No _____

29. Did you continue to grow taller after age 16? Yes _____ No _____

30. Ever married? _____ Children? _____

Please Circle the Symptoms or Traits that Apply to You

-- poor stress control

-- sensitivity to bright lights

-- morning nausea

-- tendency to delay or skip breakfast

-- very dry skin

-- pale skin, inability to tan

-- high irritability and temper

-- history of underachievement

-- little or no dream recall

-- autoimmune disorders

-- white spots on fingernails

-- ringing in the ears

-- history of perfectionism

-- stretch marks (striae) on skin

-- severe depression

-- fear of airplane travel, tornadoes, etc.

-- obsessions with negative thoughts

-- delayed puberty

-- dark or mauve-colored urine

-- abnormal EEG

-- sleep problems

-- social isolation

-- dry eyes and mouth

-- poor short-term memory

-- sensitivity to loud noises

-- affinity for spicy and salty foods

-- tendency to be overweight

-- obsessive/compulsive tendencies

-- extreme mood swings

-- history of a reading disorder

-- severe inner tension

-- frequent infections

-- premature graying of hair

-- competitive in sports

-- poor muscle development

-- “fruity” breath and/or body odor

-- spleen-area pain

-- severe anxiety

-- very strong willed

-- joint pains

-- poor wound healing

-- psoriasis

-- tendency to stay up very late

-- seasonal allergies (ragweed, pollens, etc)

-- enjoys spicy foods

-- artistic or musical ability

Medical History

Primary Symptoms _____

_____

Onset of condition: _____

Treatments that were effective: _____

_____

Treatments that failed _____

_____

Any family members with similar symptoms? _____

_____

Please circle any of the following that apply to a relative:

temper tantrums	ADD/ADHD	cancer
panic disorder	anxiety disorder	dementia
asthma	ulcers	heart disease
stroke	bipolar disorder	kidney problems
depression	autism	psoriasis
diabetes	arthritis	schizophrenia