

# HEALTH HISTORY QUESTIONNAIRE

New Harmony Center for Health & Wellness  
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**Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. Please bring this questionnaire and any recent medical tests to your Initial Evaluation.**

**All information is strictly confidential.**

## I. General Patient Information

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_  Yes, it is ok to *occasionally* email me with clinic updates, etc. My information will remain private.

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Guardian (if under 18): \_\_\_\_\_

Gender: M F Height: \_\_\_'\_\_\_" Weight: \_\_\_\_\_ lbs.

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Other physicians/ therapists seen for this condition: \_\_\_\_\_

Medications (if any): \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Supplements (any vitamins, herbs, mineral, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Care Providers you regularly see (primary care, chiropractors, therapists, bodywork practitioners, etc.)

Please list names, addresses, & phone numbers.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major Complaint(s), in order of significance to you:

Severe    Moderate    Slight    Normal

	Severe	Moderate	Slight	Normal
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do these conditions impair your daily activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## II. Patient Medical History

How was your childhood health? \_\_\_\_\_  
\_\_\_\_\_

Hospital Visits/  
Stays: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Recent tests: (please indicate test results and date below)

Physical                       Cholesterol                       Prostate                       Blood (which?)  
 HIV/STD                       Pap smear                       Mammography                       Other: \_\_\_\_\_

Test Results and Date: \_\_\_\_\_  
\_\_\_\_\_

Check any you have had in the past:

- |  |                                       |   |  |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder    |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Emphysema           |
| <input type="checkbox"/> Jaundice      | <input type="checkbox"/> Gonorrhea    | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Bleeding tendency   |
| <input type="checkbox"/> Syphilis      | <input type="checkbox"/> Measles      | <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Nervous disorder    |
| <input type="checkbox"/> Meningitis    | <input type="checkbox"/> HIV          | <input type="checkbox"/> Polio          | <input type="checkbox"/> Mononucleosis       |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> High fever   | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Paralysis     | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Migraines      | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Other: _____  |                                       |   |  |

Immunizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

### III. Family History

Family Member	Alive	Deceased	Present Health or Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	
Child	<input type="checkbox"/>	<input type="checkbox"/>	
Child	<input type="checkbox"/>	<input type="checkbox"/>	
Child	<input type="checkbox"/>	<input type="checkbox"/>	
Child	<input type="checkbox"/>	<input type="checkbox"/>	
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	

Where are you in the birth order?       First       Middle       Only

Check the following that have occurred in your blood relatives:

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Heart disease   | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Bleeding tendency   |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Nervous illness | <input type="checkbox"/> Mental illness      |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Other _____  |  |  |

#### IV. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

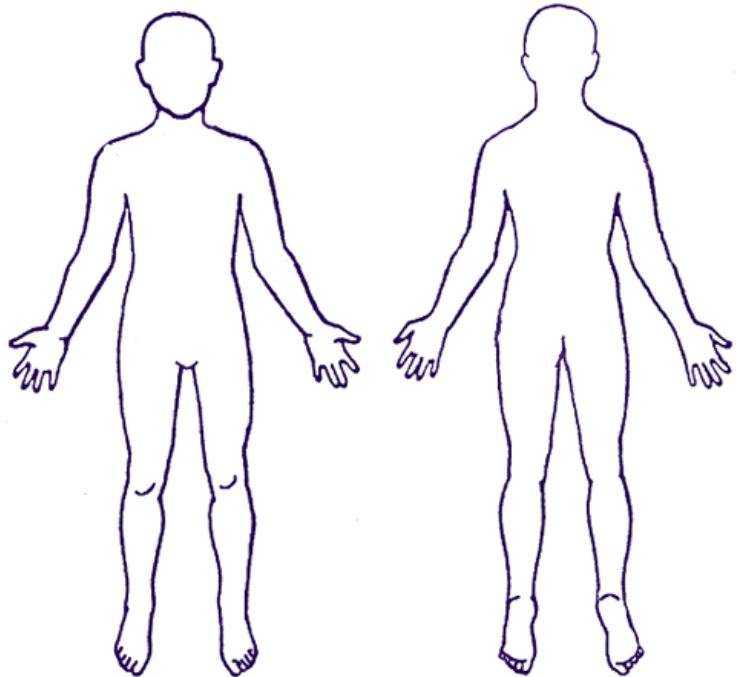
- Sharp       Burning       Aching
- Cramping    Dull             Moving
- Fixed         Other: \_\_\_\_\_

Do the following lessen the pain?

- Pressure     Cold             Heat
- Exercise
- Other: \_\_\_\_\_

Do the following worsen the pain?

- Pressure     Cold             Heat
- Other: \_\_\_\_\_



Please check the following that currently pertain to you.

#### Overall Temperature (Kidney function):

- Cold hands
- Cold feet
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed
- Difficulty keeping eyes open in the daytime

#### Overall energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

#### Blood (Liver, Spleen, Heart function):

- Dizziness
- See floating black spots

#### Heart function:

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# of cups per week: \_\_\_\_\_)

**Lung function:**

- Nasal Discharge (Color: \_\_\_\_\_)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry Nose
- Dry Skin
- Allergies  
(To what? \_\_\_\_\_)
- Alternating fever and chills
- Sneezing
- Headache  
(Location: \_\_\_\_\_)
- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Smoke cigarettes  
(# of cigarettes per day: \_\_\_\_\_)
- Sadness
- Melancholy

**Spleen function:**

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed, Which organ? \_\_\_\_\_)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

**Spleen, Stomach, Large Intestine, Small Intestine function:**

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools

- Undigested food in stools

**Dampness trapped in the body:**

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

**Stomach function:**

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting

**Liver, Gall Bladder function:**

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress  
(What causes the stress?  
\_\_\_\_\_)

- Skin rashes
- Headache at the top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions

- Lump in the throat
- Neck tension
- Limited Range-of-Motion, Neck
- Shoulder tension
- Limited Range-of-Motion, Shoulder
- Drink alcohol
- Recreational drugs  
(Which? \_\_\_\_\_,  
How much per week? \_\_\_\_\_)
- High-pitched ringing in the ears
- Gall stones (history or current)
- Sexually transmitted disease  
(Which? \_\_\_\_\_)

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

Kidney, Urinary Bladder function:

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems

Other symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones
- Bladder infections
- Wake during the night twice or more to urinate
- Lack of bladder control
- Fear
- Easily startled

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Painful
- Urgent
- Frequent

Libido:

- Normal
- High
- Low

**Women only:**

Regular menstrual cycle?  Y  N

Pregnant?  Y  N

Number of children: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Age of first menstruation: \_\_\_\_\_

Age of menopause (if applicable): \_\_\_\_\_

Average number of days of flow: \_\_\_\_\_

Average number of days of entire cycle: \_\_\_\_\_

	Severe	Moderate	Slight	Normal
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following pre-menstrual syndromes?

- Nausea
- Vomiting
- Water retention
- Breast swelling
- Food cravings
- Headaches
- Migraines
- Breast tenderness
- Depression
- Irritability
- Anxiety
- Other emotions: \_\_\_\_\_
- Dull pain, where? \_\_\_\_\_
- Sharp pain, where? \_\_\_\_\_

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

**Men only:**

- Swollen testes
- Testicular pain
- Impotence
- Premature ejaculation
- Feeling of coldness or numbness in external genitalia
- Other \_\_\_\_\_