

Client: \_\_\_\_\_

Date: \_\_\_\_\_

## Health History

Please indicate conditions that you have or have had in the past year.

### Pain, Numbness, or Weakness in:

- |   |  |
|---|--|
| Current <input type="checkbox"/> Past <input type="checkbox"/> Hands/Wrists | Current <input type="checkbox"/> Past <input type="checkbox"/> Hips        |
| Current <input type="checkbox"/> Past <input type="checkbox"/> Arms         | Current <input type="checkbox"/> Past <input type="checkbox"/> Knees       |
| Current <input type="checkbox"/> Past <input type="checkbox"/> Shoulders    | Current <input type="checkbox"/> Past <input type="checkbox"/> Feet/Ankles |
| Current <input type="checkbox"/> Past <input type="checkbox"/> Neck         | Current <input type="checkbox"/> Past <input type="checkbox"/> Jaw/TMJ     |
| Current <input type="checkbox"/> Past <input type="checkbox"/> Back         |  |
| Current <input type="checkbox"/> Past <input type="checkbox"/> Legs         |  |
| Current <input type="checkbox"/> Past <input type="checkbox"/> Other _____  |  |

### Muscles/Joints/Tendons/Bones:

- Current  Past  Swollen Joints  
 Current  Past  Cramps or Spasms  
 Current  Past  Tremors

Type of Pain: \_\_\_\_\_

(burning, aching, sharp,stabbing, etc)

### Eyes/Ears/Nose/Throat:

- Current  Past  Blurred/Failing vision  
 Current  Past  Red Eyes  
 Current  Past  Itchy/Dry eyes  
 Current  Past  Spots in front of eyes  
 Current  Past  Ringing in ears  
 Current  Past  Earache  
 Current  Past  Loss of hearing  
 Current  Past  Sinus congestion  
 Current  Past  Nosebleeds  
 Current  Past  Hay fever/allergies  
 Current  Past  Frequent colds  
 Current  Past  Sore throat  
 Current  Past  Cough  
 Current  Past  Phlegm Color: \_\_\_\_\_  
 Current  Past  Hoarseness  
 Current  Past  Dry mouth/throat  
 Current  Past  Mouth sores/Canker sores

### Temperature:

- Current  Past  Cold hands or feet  
 Current  Past  Chills  
 Current  Past  Hot flashes  
 Current  Past  Fever or heat sensations  
 Current  Past  Sweating

### Cardiovascular:

- Current  Past  Angina  
 Current  Past  Chest pain  
 Current  Past  Arteriosclerosis  
 Current  Past  Heart attack  
 Current  Past  MI  
 Current  Past  High blood pressure  
 Current  Past  Low blood pressure  
 Current  Past  High cholesterol  
 Current  Past  Irregular heartbeat  
 Current  Past  Rapid heartbeat  
 Current  Past  Palpitations  
 Current  Past  Poor circulation  
 Current  Past  Swollen ankles  
 Current  Past  Congestive heart failure

### Emotional symptoms:

- Current  Past  Anger/Irritability  
 Current  Past  Anxiety/Nervousness  
 Current  Past  Depression  
 Current  Past  Easily startled  
 Current  Past  Indecisive  
 Current  Past  Excessive fear  
 Current  Past  Excessive grief  
 Current  Past  Excessive worry  
 Current  Past  Forgetfulness  
 Current  Past  Difficulty focusing  
 Current  Past  Mania/hypomania  
 Current  Past  Suicidal thoughts

### General:

- Current  Past  Insomnia  
 Current  Past  Poor sleep  
 Current  Past  Awaken early  
 Current  Past  Headaches/Migraines  
 Current  Past  Dizziness/Vertigo  
 Current  Past  Fatigue/Tiredness  
 Current  Past  Excessive thirst

### Skin:

- Current  Past  Acne  
 Current  Past  Boils  
 Current  Past  Cysts  
 Current  Past  Bruise easily  
 Current  Past  Dry skin  
 Current  Past  Hair and/or nail problems  
 Current  Past  Itching  
 Current  Past  Rash  
 Current  Past  Hives  
 Current  Past  Eczema  
 Current  Past  Night sweating  
 Current  Past  Day sweating

### Genito/Urinary:

- Current  Past  Blood/pus in urine  
 Current  Past  Frequent urination  
 Amount: Scant  Profuse   
 Current  Past  Incontinence/Unable to control urine  
 Current  Past  Kidney infection/stones  
 Current  Past  Low libido  
 Current  Past  Other \_\_\_\_\_

### Gastrointestinal:

- Current  Past  Belching  
 Current  Past  Bloating  
 Current  Past  Gas  
 Current  Past  Colitis  
 Current  Past  Colon problems  
 Current  Past  IBS  
 Current  Past  Constipation  
 Current  Past  Diarrhea  
 Current  Past  Bloody stools  
 Current  Past  Difficulty swallowing  
 Current  Past  Distention of abdomen  
 Current  Past  Excessive hunger  
 Current  Past  Gall bladder problems  
 Current  Past  Hemorrhoids  
 Current  Past  Indigestion  
 Current  Past  GERD  
 Current  Past  Acid reflux  
 Current  Past  Nausea  
 Current  Past  Pain in stomach area  
 Current  Past  Poor appetite  
 Current  Past  Vomiting  
 Current  Past  Other \_\_\_\_\_

### For Men Only:

- Current  Past  ED/Impotence  
 Current  Past  Hernia/Groin pain  
 Current  Past  Penis discharge  
 Current  Past  Premature ejaculation  
 Current  Past  Prostate problems

### For Women Only:

- Age of first menses: \_\_\_\_\_  
 Days between menses: \_\_\_\_\_  
 Number of pregnancies: \_\_\_\_\_  
 Current  Past  Miscarriages: # \_\_\_\_\_  
 Current  Past  Clots in menses  
 Current  Past  Bleeding between periods  
 Current  Past  Irregular cycles  
 Current  Past  Menopausal symptoms  
 Current  Past  PMS  
 Current  Past  Light periods  
 Current  Past  Heavy periods  
 Current  Past  Painful periods  
 Current  Past  Spotting/scanty flow  
 Current  Past  Yeast infections  
 Current  Past  Other \_\_\_\_\_

