



Health Information and History

Please fill out this information as best as you can. If you are unclear on questions we can discuss them during our visit. Some questions may seem unrelated to your condition, yet they do help us in creating a deeper understanding of your individuality. *All information will be held strictly confidential.*

General Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Employer: _____

Guardian (if under 18): _____

Age: _____ DOB: ____/____/____ Place of Birth: City: _____ State: _____

Relationship Status: _____ Height: _____ Weight: _____

Children: _____ Do you share your home with if others if so whom? _____

Referred by: _____ Family Physician: _____

Objectives

What do you want to achieve or change in terms of your health and wellness? _____

How would your life be different if you were to achieve these objectives to your satisfaction? _____

Personal History

How was your childhood health? _____

Hospital Visits/Stays: _____

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Do you or your family members have a history of:

	Family Member				Family Member		
	Myself	Maternal	Paternal		Myself	Maternal	Paternal
Allergies to Food or Drugs	Yes[]	Yes[]	Yes[]	Hepatitis Non-A, Non-B	Yes[]	Yes[]	Yes[]
Anemia	Yes[]	Yes[]	Yes[]	High Fever	Yes[]	Yes[]	Yes[]
Arthritis	Yes[]	Yes[]	Yes[]	HIV Exposure	Yes[]	Yes[]	Yes[]
Asthma, Pneumonia, TB	Yes[]	Yes[]	Yes[]	Implant, Prosthesis	Yes[]	Yes[]	Yes[]
Blood Pressure – High or Low	Yes[]	Yes[]	Yes[]	Kidney or Bladder Disease	Yes[]	Yes[]	Yes[]
Cancer: _____	Yes[]	Yes[]	Yes[]	Measles	Yes[]	Yes[]	Yes[]
Chemotherapy/Radiation Treatment	Yes[]	Yes[]	Yes[]	Meningitis	Yes[]	Yes[]	Yes[]
Chest Pain/Angina	Yes[]	Yes[]	Yes[]	Mononucleosis, Jaundice, Gallstone	Yes[]	Yes[]	Yes[]
Chicken Pox	Yes[]	Yes[]	Yes[]	Multiple Sclerosis	Yes[]	Yes[]	Yes[]
Contact Lenses	Yes[]	Yes[]	Yes[]	Mumps	Yes[]	Yes[]	Yes[]
Dental Treatment Complications	Yes[]	Yes[]	Yes[]	Nervous Disorder	Yes[]	Yes[]	Yes[]
Diabetes	Yes[]	Yes[]	Yes[]	Pain or Ringing in the Ear	Yes[]	Yes[]	Yes[]
Dizziness	Yes[]	Yes[]	Yes[]	Paralysis	Yes[]	Yes[]	Yes[]
Emphysema	Yes[]	Yes[]	Yes[]	Polio	Yes[]	Yes[]	Yes[]
Epilepsy, Convulsions, Seizures	Yes[]	Yes[]	Yes[]	Popping, Clicking, Locking of the Jaw	Yes[]	Yes[]	Yes[]
Fainting	Yes[]	Yes[]	Yes[]	Prolonged Bleeding when Cut	Yes[]	Yes[]	Yes[]
Feet or Ankles, Swelling	Yes[]	Yes[]	Yes[]	Psychiatric Treatment	Yes[]	Yes[]	Yes[]
Glaucoma, Eye Surgery	Yes[]	Yes[]	Yes[]	Rheumatic Fever	Yes[]	Yes[]	Yes[]
Headaches, Migraines	Yes[]	Yes[]	Yes[]	Shortness of Breath	Yes[]	Yes[]	Yes[]
Heart Attack	Yes[]	Yes[]	Yes[]	Stroke / Cerebro Vascular Accident	Yes[]	Yes[]	Yes[]
Heart Disease, Heart Murmur	Yes[]	Yes[]	Yes[]	Thyroid Disease or Medication	Yes[]	Yes[]	Yes[]
Heart Surgery	Yes[]	Yes[]	Yes[]	Ulcers, Intestinal Bleeding	Yes[]	Yes[]	Yes[]
Hepatitis A	Yes[]	Yes[]	Yes[]	Upper respiratory problems	Yes[]	Yes[]	Yes[]
Hepatitis B	Yes[]	Yes[]	Yes[]	Veneral Diseases	Yes[]	Yes[]	Yes[]

History of any other disease or problems? (Please list any other illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, lifestyle conditions, addictions, alcohol, drug abuse, changes of weight or anything else to help clearly understand your health condition)

Family history: Any other family illnesses? _____

Concerns: Major concerns/complaint(s), in order of significance to you (please note how long they have troubled you):

1. _____
2. _____
3. _____
4. _____

How do these conditions impair your daily activities? _____

Please describe any other conditions that are currently bothering you, such as: Aches, pains, degenerative illnesses, anxiety, depression, stress, fatigue, energy levels, mental clarity, concentration, insomnia, vision, fever, hot flashes, chills, nausea, constipation, diarrhea, sleep habits, nervousness or other conditions you can think of.

Current treatment: Are you currently under a physician's care for a specific medical problem or condition? If so, what?

Last physical examination (date)? _____

What prescription drugs or medications are you currently taking? _____

What non-prescription drugs, medications or substances or recreational drugs are you taking? (Please note duration)

What surgeries have you had? (Please list dates) _____

Other: Do you currently engage in any exercise or physical activity? If so, what type and how often? _____

Have you ever done Yoga postures before? If so, what type and how often? _____

Gender specific: Women: Age of first menstruation: _____ Last menstrual period? _____

Are your periods regular? _____ How long does your period last? _____ Do you have bleeding

between periods? _____ Any clotting? _____ What color is the blood? _____

Days between periods (i.e., days between the first day of each period)? _____ Do you have vaginal discharge? _____

Are you pregnant? _____ Number of pregnancies? _____ Number of children? _____

Do you experience any of the following pre-menstrual or menstrual symptoms:

Fear, anxiety	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Scanty, infrequent or no menstruation	<input type="checkbox"/>	Profuse menstrual flow	<input type="checkbox"/>	Prolonged, slow menstrual cycle	<input type="checkbox"/>
Sharp pain	<input type="checkbox"/>	Burning pain	<input type="checkbox"/>	Dull pain	<input type="checkbox"/>
		Sensitive nipples	<input type="checkbox"/>	Enlargement of breasts	<input type="checkbox"/>
		Tender breasts	<input type="checkbox"/>	Edema (swelling)	<input type="checkbox"/>

Please describe any other menstrual symptoms, such as: Nausea, vomiting, food cravings, headaches, migraines, other emotions, etc.: _____

Age of menopause (if applicable): _____

Gender specific: Men: Do you have any of the following symptoms:

Testicular pain	<input type="checkbox"/>	Swollen testes	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	Premature ejaculation	<input type="checkbox"/>

Please describe any other symptoms: _____

Both genders: (Please circle) Would you describe your libido as Low Average High

Please describe any urinary symptoms, such as: Difficult, burning, painful, frequent, urgent, etc.: _____

Please describe any bowel symptoms, such as: Pain, gas, blood, mucous, etc.: _____
