**HEALTH HISTORY QUESTIONNAIRE**
Information for your Practitioner

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. All information is strictly confidential.

## I. General Patient Information

Date: ____/____/____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Age: _____ Date of Birth: ____/____/____ Place of Birth:_____

Email address: _____

Gender: __M __F Height: ____'____" Weight: _____lbs.

Primary Care Doctor: _____

Occupation:_____Employer:_____

How did you hear about our office/REFERRED BY?
_____

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

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

Additional:_____

**Miscellaneous:**

Sleep:
Approximately how many hours do you sleep per night? _____
Do you have trouble falling asleep? __Y __N
Do you have trouble staying asleep? __Y __N
Do you feel rested when you awake? __Y __N

Are you currently taking any medications? __Y __N If yes please list:
_____
_____
_____
_____
_____

Are you taking any herbs/supplements? __Y __N If yes please list:
_____
_____
_____

Please check if you eat any of the following foods:

__Fruit __Vegetables __Dairy (milk, yogurt, cheese) __Wheat (bread, pasta, cereal, etc.)
__Fish __Meat __Poultry __Eggs __Nuts/Seeds __Soda __Sweets (candy, ice cream, cookies)
__Rice __Other grains __Potatoes/Tomatoes/Peppers __Soy (tofu, miso, soy sauce)
__Artificial sweeteners __Packaged/Canned food

Do you exercise at least 2-3 times per week? __Y __N If yes which type:

_____

1. Are you discouraged with your current health status? ____Yes ____No

2. Do you smoke cigarettes? ____Yes ____No If so, how many per day? _____

3. How many caffeinated drinks do you consume per day? _____

4. How many servings of alcohol do you drink per week? _____

5. Past injuries, accidents or surgeries: _____
_____
_____
_____

6. Marital Status: _____

7. Number of children: _____

8. On a scale of 1-10, with ten being the highest, how committed are you in wanting to rid yourself of these problems and feeling great? _____ If below 8, what is the reservation?

_____

9. What are 3 health goals that you would like to accomplish in the next 3-6 months?

1)_____
2)_____
3)_____

10. Assuming that we could help you with your condition, is there anything that would prevent you from following through with the treatment plan? ____Yes ____No

11. Are there any other barriers to your commitment, e.g., time, transportation, other? Please specify:
_____

_____