

Changewater Wellness Center

Health History Questionnaire

Case Number: _____

This is a confidential record of your history which will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so as outlined in the privacy policy.

This is a fillable form pdf. Please fill in the shaded areas, save the file, and return via email.

Date _____

Name (Last) _____ First _____

Street _____

City _____ State _____ Zip _____

Email Address _____

Day Phone (_____) _____ - _____ Evening Phone (_____) _____ - _____

Fax (_____) _____ - _____

Date of Birth ____/____/____ Height _____ Age _____ Gender _____

Current Weight _____ Weight 1 Year Ago (if known) _____

Occupation _____ Marital Status _____

Emergency Contact _____ Phone (_____) _____ - _____

Family Physician _____ Phone (_____) _____ - _____

How did you hear about Changewater Wellness Center? _____

Primary concerns and goals

1. _____

2. _____

3. _____

Health History

Has a physician given a diagnosis for the above concerns? _____

What diagnostic tests have you had done?

When did these issues begin? What you have tried for the conditions? Have the conditions changed?

If you are currently working with other health care professionals, list practitioner name and conditions treated.

Practitioners Name _____

Condition _____

Practitioners Name _____

Condition _____

Practitioners Name _____

Condition _____

List all allergies or sensitivities (i.e.: gluten, wheat, nuts, soy, eggs, etc.) _____

Significant traumas, hospitalizations and any surgeries (note date and reason)

Medications and Supplements

List **all** medications, over the counter supplements and any herbs you are **currently** using.
Please note the dosage and time of day taking:

Name of Medication / Supplement / Herbs	Dose	Time(s) of Day

List any significant medications or supplements you have taken **in the last 10 years**, why you took it, and your reaction to the medication (if any):

Name of Medication / Supplement / Herbs	Reason Taken	Reaction (if any)

Family Medical History

Please complete this section concerning family members with significant health issues

	Age (if deceased, age and cause of death)	Health
Father		
Mother		
Brothers/Sisters		

Systems Review

Before each item below please list severity of issue.

Range 0 – 10 (0 = not an issue, 10 = severe issue). Note location if specific.

Skin & Hair

- | | |
|---|---|
| ___ Skin eruptions (rashes, etc.) _____ | ___ Moles |
| ___ Itching | ___ Dry skin |
| ___ Whole body crawling sensation | ___ Oily skin |
| ___ <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis | ___ Cracks or fissures |
| ___ Hives | ___ Bruise easily |
| ___ Dandruff | ___ <input type="checkbox"/> Skin tags <input type="checkbox"/> Warts |
| ___ Poorly healing sores | ___ Athletes foot |
| ___ <input type="checkbox"/> Acne <input type="checkbox"/> Boils <input type="checkbox"/> Cysts | ___ Other skin infections, color or skin texture changes |

Head, Eyes, Ears, Nose & Throat

- | | |
|---|--|
| ___ Headaches how often _____ | ___ Cold sores or canker sores |
| ___ Migraine how often _____ | ___ Cracks around mouth or chapped lips |
| ___ Dizziness | ___ Sinus congestion |
| ___ Facial pain | ___ Frequent sinus infections |
| ___ Swollen glands | ___ Sinus headaches |
| ___ Earaches or ear infections | ___ Nose bleeds |
| ___ Tinnitus (ringing in ears) | ___ Frequent colds or sore throat |
| ___ <input type="checkbox"/> Eye pain <input type="checkbox"/> Tearing <input type="checkbox"/> Dryness | ___ Post nasal drip |
| ___ <input type="checkbox"/> Itchy ears <input type="checkbox"/> Itchy eyes | ___ Hay fever |
| ___ Poor hearing | ___ <input type="checkbox"/> Teeth grinding <input type="checkbox"/> Bleeding gums |
| ___ Poor vision or blurred vision, day/night | ___ Clicking jaw |
| ___ Spots in front of eyes | |
| ___ <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma | |

Endocrine

- | | |
|------------------|------------------|
| ___ Hypothyroid | ___ Hyperthyroid |
| ___ Hypoglycemia | ___ Diabetes |

Cardiovascular

- Blood pressure _____ / _____
- | | |
|-------------------------------------|---------------------------------|
| ___ Irregular heart beat | ___ Palpitations |
| ___ Murmur or Mitral Valve Prolapse | ___ Racing or pounding heart |
| ___ Cold hands, feet or body | ___ Dizzy when standing quickly |
| ___ Tingling in hands or feet | ___ Fainting |
| ___ Varicose or spider veins | ___ Swelling in ankles or hands |
| ___ Chest pain or tightness | |

Respiratory

- Never Smoked Presently Smoke Smoked in the Past How many years? _____ Daily Amount _____
- ____ Difficulty breathing with exertion without exertion
- ____ Difficulty breathing when lying down
- ____ Cough Dry Wet Blood
- ____ Bronchitis
- ____ Pneumonia
- ____ Colds always settle in lungs
- ____ Production of phlegm No Yes Color: Clear/White Yellow/Green Blood
- ____ Pain with breathing Inhale Exhale
- ____ Rapid or shallow breather
- ____ Asthma
- ____ Past exposure to environmental pollutants

Gastrointestinal

- ____ Food cravings _____
- ____ Bloating after eating
- ____ Burping, belching
- ____ Fatigue after eating
- ____ Nausea AM PM
- ____ Vomiting
- ____ Indigestion
- ____ Abdominal pain Upper Lower Mid
- ____ Poor appetite
- ____ Bad breath
- ____ Heartburn
- ____ Acid or sour taste in mouth
- ____ Stomach upset easily
- Do you use antacids? Yes No
- ____ Difficulty swallowing
- ____ Gas
- ____ Discomfort under rib cage left side right
- ____ Difficulty losing weight gaining weight
- ____ Stomach pain before eating after eating
- ____ History of ulcers or current ulcer
- ____ Hemorrhoids or rectal pain
- ____ History of diarrhea
- ____ History of constipation
- ____ Rapid elimination after meal
- ____ # bowel movements per day
- Loose Normal Mucus Blood
- Hard Small Narrow or Thin
- Color: black brown yellow tan

Urinary

- ____ Urinary frequency Small amounts? _____
- ____ Painful urination
- ____ Incontinence
- ____ Kidney or Bladder infections
- ____ Dribbling after urination
- ____ Up at night to urinate # of times _____
- ____ Infrequent urination large amounts
- ____ Kidney stones: # of times _____ current
- ____ Urine has strong odor
- ____ Urine color: light dark blood cloudy
- ____ Irregular flow
- ____ Decreased flow

Musculoskeletal

- ___ Aching muscles
- ___ Muscle pain or spasms
- ___ AM stiffness that last for more than 1 hour after waking
- ___ As you use muscle the stiffness gets worse
- ___ Stiffness better with movement
- ___ Reduced range of motion – where _____
- ___ Back pain – Location: Low Mid Upper
- ___ Joint pain – location(s) _____
- ___ Broken bones – location(s) _____
- ___ Arthritis – location(s) _____
- ___ Neck pain
- ___ Use chiropractor _____ times per month
- ___ Massage/Other Bodywork _____ times per month
- ___ Sciatica
- ___ Scoliosis
- ___ Weak or Tired Legs

Sleep Pattern

- ___ Difficulty falling asleep
- ___ Mind doesn't turn off
- ___ Interrupted sleep (at what time[s]?) _____
- ___ Still tired in AM fatigue foggy
- ___ Dreams bad vivid
- ___ Sleep Aids? What and how often _____
- ___ Bedtime _____ Wake up time _____

Emotional

- | | |
|------------------------------|--|
| ___ Stress level | ___ Spacey/foggy feeling |
| ___ Irritable | ___ Highly emotional |
| ___ Frustration | ___ Depressed |
| ___ Anger | ___ Cry easily |
| ___ Difficulty concentrating | ___ Fearful |
| ___ Poor memory | ___ Overactive mind/excessive thinking |
| ___ Loss of balance | ___ Panic attacks |
| ___ Anxiety | |

Immune System

- Hayfever
- Animal Dander, Mites, etc.
- Bronchial Infections
- Mononucleosis
- HIV/AIDS
- Fibromyalgia
- Chronic Fatigue Syndrome
- Interstitial Cystitis
- Scleroderma
- Molds, Mildew, Fungus Sensitivities/Allergy
- Food Intolerances
- Frequent Colds/Flu
- Cancer, Where? _____
- Epstein Barr Syndrome
- Cytomegalovirus
- Lupus
- Rheumatoid Arthritis
- Crohn's
- Hepatitis
- Lyme's

Exercise

Do you exercise? How often and length of time?

General

- Fatigue
- Facial twitches
- Increase or decrease in weight recently
- Excessive thirst
- More than 3 colds per year
- Intolerant to heat cold
- Sensitive to humidity (makes you uncomfortable)

Habits

Do you drink alcohol? No Yes If yes, what is the frequency and amount? _____

Do you have a history of alcohol or drug abuse? _____

How often do you drink any of the following?

- Coffee _____ Tea _____ Caffeinated
- Soda _____ Diet Caffeine

