WellPoint Healing Center

Health History

Please take the time to fill out this questionnaire carefully. The information provided will assist in formulating a complete health profile for you. Your answers are confidential. If you have questions, please ask.

Name ______________________________ **Date** ______________

Address ____

City ________________________ **State** __________ **Zip** __________

Home Phone ____________________ **Work Phone** ____________________

Cell Phone ____________________ **Email** ________________________

Date of Birth ______________ **Age** ______ **Marital Status** ______________

Referred By ____________________ **Your Occupation** ________________

Physician ______________________ **Dr Phone** ____________________

Physician Address ______________________________________

Emergency Contact ____________________ **Phone** ________________

Main Complaint (sympoms, diagnosis, duration, etc) ______________________________

____

____

Personal Significant Trauma (physical or emotional) ____________________________

____

Your Birth History (prolonged labor, forceps, complications, etc) ____________________

____

Surgeries (please include approximate date)

____

Allergies (chemical, environmental, food, etc)

____

Medications (names & dosages) Please attach additional sheet if necessary.

____

Vitamins / Supplements / Herbs

____

Exercise

Days per Week __________ Length of Workout __________ Type of Activity ____________________

Diet

Meals per Day __________ Snacks __________ Caffeinated Drinks __________ Alcohol per Week __________

Personal History: Please check any you have / have had in the past.

- ☐ Addiction
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ COPD
- ☐ Diabetes
- ☐ Diverticulitis/IBS
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Food Intolerance/Allergies
- ☐ Gallbladder disease
- ☐ Gastritis/Pancreatitis
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ Hypo/Hyperglycemia
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver/Gallbladder Disease
- ☐ Lyme Disease
- ☐ Raynaud's
- ☐ Respiratory Allergies
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Imbalance
- ☐ Tremors
- ☐ Ulcer

Family Medical History: Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to your choice.

- ☐ Allergies _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure ____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Other _____________

Please check if you have had any of these in the ***past 3 months.***

General

- ☐ Always hot or cold
- ☐ Bleed/Bruise easily
- ☐ Change in Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Fatigue
- ☐ Fevers
- ☐ Hot flashes
- ☐ Localized Weakness
- ☐ Muscle weakness/fatigue
- ☐ Night Sweats
- ☐ Peculiar tastes/smells
- ☐ Poor Appetite
- ☐ Poor Balance
- ☐ Poor Sleep
- ☐ Strong thirst (hot or cold)
- ☐ Sudden Energy Drop
- ☐ Sweats Easily
- ☐ Tremors
- ☐ Weight Loss/Gain

Skin and Hair

- ☐ Acne
- ☐ Change in skin/hair
- ☐ Dandruff
- ☐ Dermatitis
- ☐ Eczema/Psoriasis
- ☐ Face Flushing
- ☐ Fungal Infection
- ☐ Hives/Allergic Dermatitis
- ☐ Itching
- ☐ Loss of hair
- ☐ Rashes
- ☐ Recent moles
- ☐ Skin discoloration
- ☐ Ulcerations
- ☐ Warts

Head, Eyes, Ears, Nose and Throat

- ☐ Blurred vision
- ☐ Cataracts
- ☐ Color Blindness
- ☐ Dental / Gum Problems
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Earaches
- ☐ Eye pain
- ☐ Eye strain
- ☐ Facial pain
- ☐ Glasses
- ☐ Grinding/Clenching teeth
- ☐ Headaches
- ☐ Jaw clicks/locks/TMJ
- ☐ Migraines
- ☐ Night blindness
- ☐ Nose bleeds
- ☐ Poor hearing
- ☐ Poor vision
- ☐ Recurrent sore throat/colds
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Sores on lips/tongue
- ☐ Spots in front of eyes

Cardiovascular

- ☐ Blood clots
- ☐ Chest pain or pressure
- ☐ Chest tightness
- ☐ Cold hands/feet
- ☐ Dizziness
- ☐ Fainting
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Palpitations at rest
- ☐ Shortness of breath
- ☐ Spontaneous sweating
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins

Respiratory

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough/wheezing
- ☐ Coughing blood
- ☐ Difficult inhale/exhale
- ☐ Hard to breathe when flat
- ☐ Pain with inhalation
- ☐ Pneumonia
- ☐ Production of phlegm
- ☐ Tight sensation in chest

Gastrointestinal

☐ Abdominal pain/cramps
☐ Acid reflux/GERD
☐ Bad breath
☐ Belching
☐ Bloating
☐ Black stools
☐ Blood in stools
☐ Changes in appetite
☐ Crohn's Disease
☐ Chronic laxative use
☐ Constipation
☐ Diarrhea
☐ Excessive appetite
☐ Gas
☐ Hemorrhoids
☐ Hernia
☐ IBS
☐ Indigestion
☐ Loose stools (>2BM day)
☐ Nausea
☐ Poor appetite
☐ Rectal pain
☐ Significant thirst
☐ Vomiting

Genito-Urinary

☐ Blood in urine
☐ Burning with urination
☐ Copious flow
☐ Decreased libido
☐ Dribbling after urination
☐ Herpes
☐ Hesitant urination
☐ Impotence
☐ Infections
☐ Kidney stones
☐ Nocturnal emission
☐ Pain on urination
☐ Pain in testicles
☐ Premature ejaculation
☐ Prostate issues
☐ Scanty flow
☐ Sores on genitals
☐ Unable to hold urine
☐ Urgent urination
☐ Urinary tract infections
☐ Frequent urination
☐ Night urination…What time? ____ How often? ____

GYN / Reproductive

☐ Difficult/painful intercourse
☐ Endometriosis
☐ Fibrocystic breast tissue
☐ Irregular menstruation
☐ Infertility
☐ Menopausal symptoms
☐ Ovarian Cysts
☐ Painful menstruation
☐ PMS
☐ Polycystic Ovarian Syndrome (PCOS)
☐ Uterine Fibroids
☐ Vaginal discharge
☐ Vaginal dryness
☐ Vaginal sores
☐ Age of 1st menses ______
☐ Date of last menses ________
☐ Date of last PAP/Pelvic ______
☐ Number of Pregnancies _______
☐ Number of ectopic pregnancies____
☐ Number of live births ______
☐ Number of miscarriages ______
☐ Number of abortions ______

Do you practice birth control? _____
What type? ____________________ How long? _______

Musculoskeletal

☐ Back pain
☐ Bursitis
☐ Carpal Tunnel
☐ Elbow pain
☐ Foot/ankle pain
☐ Hand/wrist pain
☐ Hip pain
☐ Knee pain
☐ Muscle tightness/stiffness
☐ Muscle weakness
☐ Neck pain
☐ Numbness
☐ Rotator cuff
☐ Sciatica
☐ Shoulder pain
☐ Sprains/strains
☐ Tendonitis

Neuropsychological

☐ ADD/ADHD
☐ Anxiety
☐ Bad temper/ irritable
☐ Concussion
☐ Depression
☐ Easily susceptible to stress
☐ Lack of coordination
☐ Manic Depression
☐ Nervousness
☐ OCD
☐ Panic attacks
☐ Poor balance
☐ Poor memory
☐ Seasonal Affective Disorder
☐ Seizures
☐ Vertigo/dizziness

Have you ever been treated for emotional problems? ☐ yes ☐ no
Have you ever considered or attempted suicide? ☐ yes ☐ no
Have you ever been treated for substance abuse? yes ☐ no

Comments: Please inform me of any other problems or concerns you would like to discuss.

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