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Health Assessment Form

Please use the back side if more room is needed

Name:______________________________________Date:____________

Address:____

City:_____________________ State:__________ Zip:______________________
Telephone
(home):_________________________(work/cell):________________________
Email address:
____

Age:______ Date of Birth: _______________ Gender: __Female /Male___
___Married __ Separated __ Divorced __ Widowed __ Single __ Partnership
Live with: __Spouse __Partner __Parents __Children __Friends __Alone
Occupation:___________________________________ Hours per week:______

How did you hear about this clinic? ____________________________________

Health History Questionnaire

What are your most important health problems? List in order of importance.
1)____
2)____
3)____
4)____
5)____
6)____

Family History

Do you have a family history of any of the following? (Please check)

You/family		you/family	
__/__	Cancer	__/__	Kidney Disease
__/__	Asthma	__/__	Tuberculosis
__/__	Diabetes	__/__	Epilepsy
__/__	Stroke	__/__	Hay Fever
__/__	Heart Disease	__/__	Arthritis
__/__	Anemia	__/__	Hives
__/__	High Blood Pressure	__/__	Mental Illness
__/__	Glaucoma	__/__	Hypothyroidism
__/__	Depression/Anxiety	__/__	Alcoholism/Drug Addiction

Hospitalizations /Surgery /Accidents

What hospitalizations or surgeries have you had? When?

____ year:________

____ year:________

____ year:________

List any accidents:

____ year:________

____ year:________

____ year:________

List any broken bones and dislocations:

____

Were you ever knocked unconscious? Y - N

Have you ever had a lapse of memory Y - N

Client Evaluation Questionnaire

1. Please rate on scale how serious you are about getting well (circle number). Not Serious <-----0 1 2 3 4 5 6 7 8 9 10-----> Very Serious

2. Are you willing to follow a treatment program designed to help you return to health? (Treating the Cause) A. Yes B. No

3. Are you willing to take nutritional and/or homeopathic supplements? A. Yes B. No

4. Are you willing to make dietary changes? A. Yes B. No

5. Are you willing to start a moderate exercise program? A. Yes B. No

6. Please rate on scale how serious you are about staying healthy after your initial intensive care. Not Serious <---0 1 2 3 4 5 6 7 8 9 10---> Very Serious

7. Have you ever been treated by a Chiropractor or Naturopath? A. Yes B. No
How were your results?____

8. Please rate your stress on scale.
Not Serious <---0 1 2 3 4 5 6 7 8 9 10---> Very Serious

9. Are any doctors or practitioners currently treating you? A. Yes B. No
If yes, please list ____
____

Other Professions Past or Present

(Artist, graphic designer, dental asst, gas station worker, painter, industry, cleaners, hairdresser, etc.)

____

Major Psychological Trauma
(emotional upsets like divorce, death, any loss, fear)

____ Age:___________
____ Age: ___________
____ Age: ___________

Serious Infections/Diseases
(pneumonia, mono, TB, cancer, heart attack, stroke, hepatits, etc)

____ Age: __________
____ Age: __________
____ Age: __________

Long periods on prescriptions or street drugs

____ Age:__________
____ Age: __________
____ Age: __________

Long visits or lived in a foreign country like India, Mexico, Africa, etc.

____ Age:__________
____ Age: __________

Treated for parasites, infection? Y - N

Vaccination History

____ Age:__________

____ Age:__________

Allergies

Are you hypersensitive or allergic to…

Any drugs? ____

Any foods? ____

Any environmentals? ____

Current Medications

- ☐ Laxatives
- ☐ Tranquilizers
- ☐ Appetite suppressants
- ☐ Birth control pills
- ☐ Sleeping Pills
- ☐ Cortisone
- ☐ Pain relievers
- ☐ Thyroid medication
- ☐ Antacids
- ☐ Antibiotics

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

Review of symptoms
Have you had, or do you have any of the following conditions:

Y= a condition you have now N= never had P= you have had before

General

Y - P – N Appendicitis
Y - P – N Polio
Y - P - N Whooping Cough
Y - P - N Anemia
Y - P - N Measles
Y - P - N Mumps
Y - P - N Chicken Pox
Y - P - N Alcoholism
Y - P - N Epilepsy
Y - P - N HIV
Y - P - N Multiple Sclerosis
Y - P - N Chills
Y - P - N Convulsions
Y - P - N Fainting
Y - P - N Fatigue
Y - P - N Fever
Y - P - N Loss of Sleep
Y - P - N Loss of Weight
Y - P - N Neuralgia
Y - P - N Sweats

Immune

Y - P - N Chronic Fatigue Syndrome
Y - P - N Chronic Swollen Glands
Y - P - N Reactions to Vaccinations
Y - P - N Chronic Infections
Y - P - N Slow Wound Healing

Neurologic

Y - P - N Seizures
Y - P - N Muscle Weakness
Y - P - N Loss of Memory
Y - P - N Vertigo or Dizziness
Y - P - N Paralysis
Y - P - N Numbness or Tingling
Y - P - N Easily Stressed
Y - P - N Loss of Balance
Y - P - N Fainting

Mental/Emotional

Y - P - N Treated for Emotional Problems
Y - P - N Mood Swings
Y - P - N Considered/Attempted suicide
Y - P - N Poor Concentration
Y - P - N Depression
Y - P - N Anxiety or Nervousness
Y - P - N Tension
Y - P - N Memory Problems

Endocrine

Y - P - N Hypothyroid
Y - P - N Hypoglycemia
Y - P - N Excessive Thirst
Y - P - N Fatigue
Y - P - N Heat or Cold Intolerance
Y - P - N Diabetes
Y - P - N Excessive Hunger
Y - P - N Seasonal Depression
Y - P - N Night Sweats

Skin

Y - P - N Rashes
Y - P - N Eczema or Hives
Y - P - N Acne/Boils
Y - P - N Color Change
Y - P - N Lumps
Y - P - N Itching
Y - P - N Hair Loss
Y - P - N Bruises Easily

Head Eyes Ears Nose Throat

Y - P - N Headaches
Y - P - N Migraines
Y - P - N Head injury
Y - P - N Jaw/TMJ problems
Y - P - N Spots in Eyes
Y - P - N Impaired vision
Y - P - N Blurriness
Y - P - N Colorblindness
Y - P - N Double vision
Y - P - N Cataracts
Y - P - N Glasses or contacts
Y - P - N Eye pain/strain
Y - P - N Tearing or dryness
Y - P - N Glaucoma
Y - P - N Impaired hearing
Y - P - N Earaches
Y - P - N Ringing
Y - P - N Dizziness
Y - P - N Frequent colds
Y - P - N Stuffy – Nose
Y - P - N Runny – Nose
Y - P - N Sinus problems
Y - P - N Nose bleeds
Y - P - N Hay fever
Y - P - N Loss of Smell
Y - P - N Frequent sore throat
Y - P - N Teeth grinding
Y - P - N Gum problems
Y - P - N Dental Cavities
Y - P - N Sores on tongue or lips
Y - P - N Hoarseness
Y - P - N Difficulty Swallowing
Y - P - N Goiter
Y - P - N Swollen glands

Gastrointestinal

Y - P - N Trouble Swallowing
Y - P - N Change in Thirst
Y - P - N Nausea
Y - P - N Vomiting Blood
Y - P - N Blood in Stool
Y - P - N Abdominal Pain/
Y - P - N Cramps
Y - P - N Belching or Passing
Y - P - N Gas
Y - P - N Black Stools
Y - P - N Liver Trouble
Y - P - N Heart Burn
Y - P - N Change in Appetite
Y - P - N Constipation
Y - P - N Diarrhea
Y - P - N Poor Digestion
Y - P - N Poor Appetite
Y - P - N Hemorrhoids
Y - P - N Ulcer
Y - P - N Gallbladder Trouble

Bowel movements: How often?________ Is this a change?_______

Respiratory

Y - P - N Cough
Y - P - N Persistent Cough
Y - P - N Spitting Up Blood
Y - P - N Asthma
Y - P - N Pneumonia
Y - P - N Emphysema
Y - P - N Pain on Breathing
Y - P - N Shortness of Breath
Y - P - N Shortness of Breath at Night
Y - P - N Tuberculosis
Y - P - N Spitting Up Phlegm
Y - P - N Wheezing
Y - P - N Bronchitis

Cardiovascular

Y - P - N Heart Disease
Y - P - N High Blood Pressure
Y - P - N Low Blood Pressure
Y - P - N Pain Over Heart
Y - P - N Poor Circulation
Y - P - N Rapid Heart
Y - P - N Slow Heart
Y - P - N Stroke
Y - P - N Varicose Veins
Y - P - N Murmurs
Y - P - N Blood Clots
Y - P - N Phlebitis
Y - P - N Rheumatic Fever
Y - P - N Swelling in Ankles
Y - P - N Palpitations/Fluttering

Urinary

Y - P - N Pain on Urination
Y - P - N Frequency at Night
Y - P - N Frequent Infections
Y - P - N Increased Frequency
Y - P - N Inability to Hold Urine
Y - P - N Kidney Stones
Y - P - N Blood in Urine
Y - P - N Kidney Infection
Y - P - N Prostate Trouble

Male Reproductive

Y - P - N Hernias
Y - P - N Testicular Pain
Y - P - N Venereal Disease
Y - P - N Impotence
Y - P - N Premature Ejaculation
Y - P - N Testicular Masses
Y - P - N Prostate Disease
Y - P - N Discharge or Sores

Female Reproductive/Breasts

Age of first menses________
Age of last menses________
Length of cycle _______days
Duration of menses _____days
Y - P - N Painful Menses
Y - P - N Heavy or Excessive Fl
Y - P - N PMS
Y - P - N PMS Symptoms?____________
Y - P - N Endometriosis
Y - P - N Ovarian cysts
Y - P - N Difficulty conceiving
Y - P - N Are Cycles Regular
Y - P - N Bleeding Between Cycles
Y - P - N Pain During Intercourse
Y - P - N Clotting
Y - P - N Discharge
Y - P - N Herpes
Y - P - N Venereal Disease
Y - P - N IUD
Y - P - N Hot flashes
Y - P - N Lump in Breast

Y - P - N Birth control?
What type?____________
Number pregnancies___
Number live births_____
Number miscarriages___
Number of abortions___
Had a mammogram ever?
Last Pap smear date?_____
Was PAP normal?

Muscles/Joints/Bones

Y - P - N Backache
Y - P - N Foot Trouble
Y - P - N Pain Between Shoulders
Y - P - N Painful tail bone
Y - P - N Stiff neck
Y - P - N Swollen Joints
Y - P - N Tremors/Twitching
Y - P - N Arm Trouble

If you have musculoskeletal pain, please complete the following:

Please mark the intensity of your pain today: 0 = no pain, 10= intense pain.

Area:____ Intensity:__________

Area:____ Intensity:__________

Area:____ Intensity:__________

Area:____ Intensity:__________

How long has this condition lasted?___________________________________

Is this condition: ___Getting worse ___The Same ___Improving

Was this caused by an injury/accident? Y - N

If no, when did you first notice it?____

Pain came on: ___Gradually ___Suddenly

The pain is: ___Occasional ___Frequent ___Constant

Describe the pain: ___Sharp (knife-like) ___Dull (toothache) ___Burning (hot)

Does the pain: ___Stay in one spot ___Radiate (shoots) ___Goes up & down spine

What time of day is the pain worst: ___Morning __Afternoon __Evening __Night ___All the time

Do you have pain in: __Legs __Feet __Arms __Hands __Left __Right

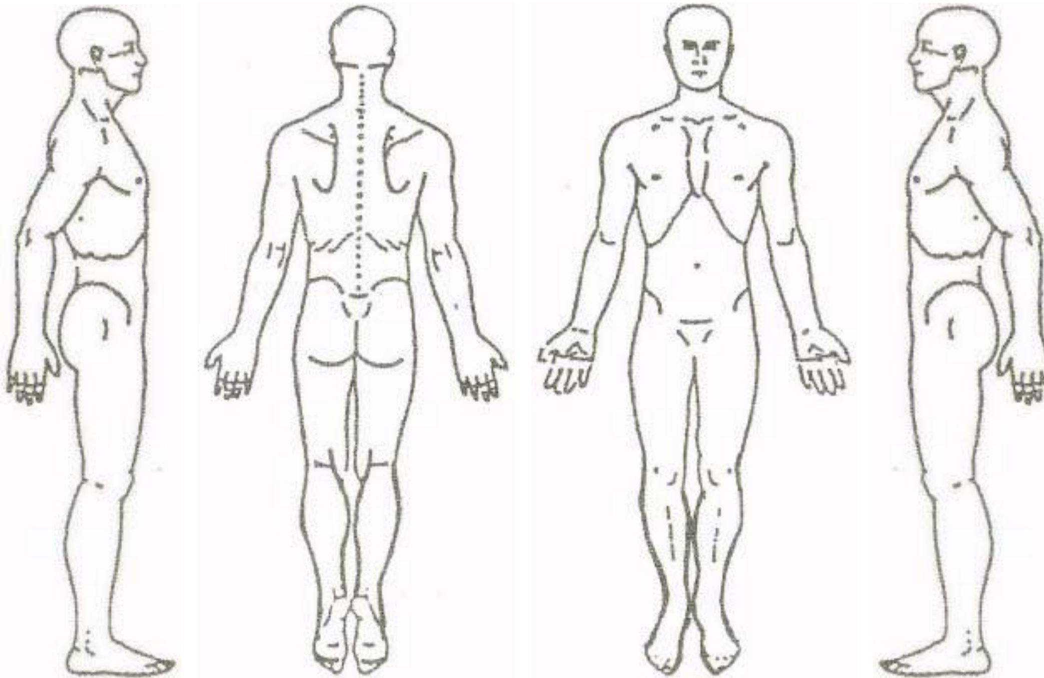
Numbness or tingling in: __Legs __Feet __Arms __Hands __Left __Right

What makes the pain worse?____

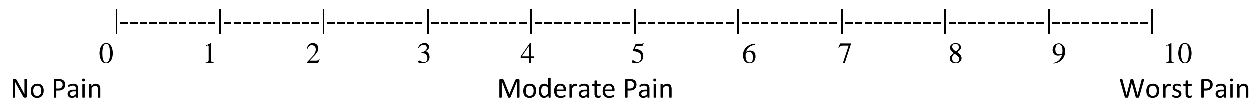
What makes the pain better?____

Does the pain affect your sleeping: __No __Occasionally __Frequently __Constantly

Circle your areas of concern or discomfort below.



Please indicate your CURRENT pain level on the chart below:



No Pain Moderate Pain Worst Pain

Current Dietary Habits

Please list what you have had to eat and drink in the last 3 days.

	Today	Yesterday	2 days ago
Breakfast:			
Snack:			
Lunch:			
Snack:			
Dinner:			
Snack:			

Is this your usual intake?

How often do you consume in an average week?

			___herbs
___bread	___milk	___beef	___herb teas
___rice	___raw milk	___lamb	___fruit
___pasta	___yogurt	___pork	___nuts
___cake	___butter	___eggs	___potatoes
___chocolate	___cheese	___soy	___organics
___candy	___soda	___beans	___vegetables
___juice	___coffee	___fish	___salad
___chips	___cereal	___energy bars	___energy drinks
___seaweed	___ice cream	___fast food	___alcohol