Vitality Natural Health and Wellness Center, LLC

"Promoting health and wellness through enhancement of the mind, body and spirit."

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTION ARE ONLY POSSIBLE WHEN THE PROVIDER HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

PATIENT: _____ DATE: _____

I. Summary of Current Conditions

What are your most important health concerns? Please list as many as you can in the order of importance. Please include the date when the condition began.

Date Began:
Date Began:
Date Began:
Date Began:
Date Began:
This condition interferes with: Work Sleep Exercise Other _____
This condition is: Getting worse Getting better Staying the same
What do you believe is the cause?
How is the condition being treated?
Do you have any known contagious diseases at this time? Yes / No If yes, what disease? _____

II. Goals and Expectations (Please tell us your goals and expectations.)

IV. Childhood Illnesses (Please check those illnesses that you have had)

☐ Scarlet Fever	☐ Diptheria	☐ Rheumatic Fever
☐ Mumps	☐ Measles	☐ German Measles

V. Immunizations

☐ Measles/Mumps/Rubella (MMR)	☐ Varicella Zoster (Chicken Pox)	☐ Diptheria/Pertussis/Tetanus (DPT)
☐ Polio	☐ Influenza	☐ Date of last Tetanus: _____
☐ Hepatitis B	☐ Date of last Flu Shot: _____	☐ Other: _____

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VI. Hospitalizations and Surgeries (What hospitalizations or surgeries have you had?)

_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____

VII. X-rays and Special Studies (X-rays, CT scans, or other studies you have had.)

_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____

VIII. Dental

Do you schedule regular cleanings? ☐ Yes ☐ No Do you wear dentures? ☐ Yes ☐ No

Have you had dental work in the last 5 year? Please explain:

Number of root canals: _____ Number of crowns: _____ Number of fillings: _____ Date of last filling: _____

IX. Allergies (Are you hypersensitive or allergic to any of the following?)

Medications: _____	Reaction: _____
Foods: _____	Reaction: _____
Environmentals: _____	Reaction: _____

X. Family History

	Father	Mother	Brothers	Sisters	Grandparents
Age (if living)					
Health (G=good; P=poor)					
Age at death (if deceased)					
Mark (X) those applicable					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Thyroid Disease					
Mental Illness					
Asthma/Hayfever/Hives					
Allergies					
Anemia					
Kidney Disease					
Glaucoma					
Tuberculosis					
Migraines					
Cancer					
Others					
Cause of Death					

XI. Medications Taken During the Last 5 Years

Category	Medication	Dosage	Now (☑)	Past (☑)	Medication	Dosage	Now (☑)	Past (☑)
Antibiotics								
Pain								
Heart								
Blood Pressure								
Cholesterol								
Depression/Anxiety/Sleep								
Hormones								
Thyroid								
Diabetes								
Digestion								
Allergies/Asthma								
Weight Control								
Skin Creams								
Other								

XII. Over the Counter Medications, Supplements, Vitamins, Herbs

Brand/Store:	Supplement:	Dosage:	Brand/Store:	Supplement:	Dosage:

XIII. Review of Symptoms (Please check the following that apply to you.)

Head	☐ Neck pain / stiffness	☐ Infections, chronic	**Urinary**
☐ Headaches	☐ Whiplash injury	☐ Slow wound healing	☐ Frequent infections
☐ Migraines	**Chest**	☐ Heat or cold intolerance	☐ Inability to hold urine
☐ Jaw / TMJ Problems	☐ Chest pain / pressure	☐ Increasing hunger / thirst	☐ Inability to empty bladder
☐ Hair Loss	☐ Palpitations / fluttering	☐ Excessive sweating	☐ Inc. urinary frequency
☐ Ear Pain	☐ Difficult breathing	☐ Night sweating	☐ Inc. frequency at night
☐ Ear Infections	☐ Pain with breathing	☐ Fainting / Lightheadedness	☐ Urgency with urination
☐ Ears, itchy	☐ Chronic cough	☐ Dizziness / Vertigo	☐ Low force of urination
☐ Hearing problems	☐ Shortness of breath	☐ Numbness or Tingling	☐ Pain with urination
☐ Ringing (ears) / Tinnitis	☐ at night	☐ Tremor	☐ Bed wetting
☐ Wax, excessive	☐ lying down	☐ Back pain	**Female**
☐ Blurry Vision	☐ with exercise /exertion	☐ Muscle pain /cramps /spasm	☐ Bleeding between cycles
☐ Color blindness	☐ Spitting up blood	☐ Muscle weakness, tiredness	☐ PMS
☐ Decreased night vision	☐ Wheezing	**Digestion / Elimination**	☐ Endometriosis
☐ Double vision	**Extremities**	☐ Abdominal / stomach pain	☐ Painful intercourse
☐ Dry, red, gritty eyes	☐ Joint pain or stiffness	☐ Belching / Burping	☐ Sexual difficulties
☐ Eyes, itchy	☐ Joint heat and redness	☐ Blood in stool	☐ Breast lumps
☐ Eye pain	☐ Joint swelling	☐ Change in stool	☐ Breast pain / tenderness
☐ Glasses / Contacts	☐ Swelling in the ankles	☐ Flatulence/ Gassiness	☐ Nipple discharge
☐ Spots in eyes / Floaters	☐ Leg Pain	☐ Difficult bowel movement	☐ Difficulty getting pregnant
☐ Tearing, excessive	☐ Cold hands and feet	☐ Change in appetite / thirst	☐ Vaginal discharge
☐ Hay fever	**Skin**	☐ Fatigue after eating	☐ Vaginal itching
☐ Nose bleeds	☐ Acne	☐ Heartburn/ Acid Reflux	☐ Vaginal dryness
☐ Red nose and/or face	☐ Rashes	☐ Nausea	☐ Genital Warts
☐ Runny nose	☐ Flushing / hot flashes	☐ Vomiting	☐ Genital Herpes
☐ Sinus problems	☐ Eczema	☐ Hemorrhoids	☐ Yeast infection, chronic
☐ Stuffiness, congestion	☐ Hives	☐ Painful stool	**Male**
☐ Frequent sore throat	☐ Boils	☐ Constipation	☐ Penile discharge
☐ Frequently clear throat	☐ Itching	☐ Diarrhea	☐ Penile sores
☐ Gum problems / Periodontal disease	☐ Color changes ☐ Lumps	☐ Alternating constipation/ diarrhea	☐ Difficulty getting / maintaining erection
☐ Hoarseness	☐ Psoriasis	☐ Pain in rectum/ anus	☐ Sexual difficulties
☐ Mouth sores	☐ Moles	☐ Itching in rectum/ anus	☐ Pain with intercourse
☐ Cold sores / Oral herpes	☐ Sun sensitivity	☐ Difficulty swallowing	☐ Testicular pain
☐ Mouth dryness	☐ Tight skin	**Mental / Emotional**	☐ Testicular lump
☐ Sore tongue, lips	☐ Easy bleeding / bruising	☐ Anxiety / nervousness	☐ Scrotal redness / rash
☐ Teeth grinding	☐ Varicose veins	☐ Poor memory	☐ Scrotal itching
☐ Swollen glands	☐ Rosacea	☐ Depression	☐ Genital Warts
☐ Tonsils/Adenoids removal	**General**	☐ Difficult concentration	☐ Genital Herpes
Neck	☐ Chronic fatigue/ tiredness	☐ Mood swings	**Other:**_____
☐ Goiter / Neck lumps	☐ Frequent colds/ infections	☐ Tension, stress	☐

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XIV. Reproductive History

Female

Date of last female exam: _____ Normal Pap? ☐ Yes ☐ No, explain: _____ Have you ever had HPV? ☐ Yes ☐ No

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bi ☐ Other Sexually active? ☐ Yes ☐ No

Birth Control Type: _____

# of Pregnancies: ____ # of Live Births: ____ # of Cesarian deliveries: ____ # of Miscarriages: ____ # of Abortions: ____

Age period began: _____ Length of period (bleeding): _____ Length of cycle: _____ Are your cycles regular? ☐ Yes ☐ No

Menstrual pain /cramps: ☐ None ☐ Mild ☐ Significant ☐ Severe

Menstrual Flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Extremely heavy

Are you pregnant? ☐ Yes ☐ No Are you breast feeding? ☐ Yes ☐ No Have you ever breast fed? ☐ Yes, how long_____ ☐ No

Were you ever on oral contraceptives? ☐ Yes, How long? _____ ☐ No Hormone Replacement: ☐ Past ☐ Current How long? _____

Uterine Fibroids: ☐ Past ☐ Current Fibrocystic Breasts: ☐ Past ☐ Current Polycystic Ovaries: ☐ Past ☐ Current

Are you menopausal? ☐ Yes, date of last period: _____ ☐ No Age: _____ Hysterectomy: ☐ Yes ☐ No

Do you do Self Breast Examination (SBE)? ☐ Yes ☐ No Date of last mammogram: _____ Normal: ☐ Yes ☐ No, explain:

Male

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bi ☐ Other Sexually active? ☐ Yes ☐ No Birth Control Type: _____

Ejaculation concerns: ☐ Yes ☐ No Fertility Concerns: ☐ Yes ☐ No Impotence: ☐ Yes ☐ No Hernia concerns: ☐ Yes ☐ No

Prostate concerns: ☐ No ☐ Yes, explain:

XV. General Review

Weight, current: Weight, 1 year ago: Maximum Weight: Ideal Weight: I consider my weight to be: ☐ Not a factor in my present illness ☐ Somewhat of a factor ☐ Not a factor Height:	Do you drink alcohol? ☐ Yes ☐ No Number of drinks/week: _____ Type of alcohol: _____ Ever been treated for alcoholism? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No Have you ever used tobacco? ☐ Yes ☐ No What type? _____ How much/day? _____ # of years: _____ Have you ever tried to quit? ☐ Yes ☐ No
Do you sleep well? ☐ Yes ☐ No Do you awaken feeling rested? ☐ Yes ☐ No Do you get enough sleep? ☐ Yes ☐ No Average hours of sleep per night:	Do you use recreational drugs? ☐ Yes ☐ No What type? _____ Ever been treated for drug dependence? ☐ Yes ☐ No
My blood type is: ☐ A ☐ B ☐ O ☐ AB ☐ + ☐ -	Have you been exposed to toxic/potentially toxic chemicals? ☐ Yes ☐ No Please list:
Do you eat three meals per day? ☐ Yes ☐ No	Ever been diagnosed with a psychiatric disorder? ☐ Yes ☐ No Did you undergo treatment? ☐ Yes ☐ No
Do you take vacations? ☐ Yes ☐ No	Do you consider yourself to be happy these days? ☐ Yes ☐ No
Average number of sick days/year:	Do you have a strong support system (i.e. family, friends, people to talk/share things with)? ☐ Yes ☐ No

Do you watch television? ☐ Yes, hrs/day: ___ ☐ No	Do you have a significant other? ☐ Yes ☐ No
How many hours per day do you use a computer? ___	Do you enjoy your work? ☐ Yes ☐ No
Do you follow a spiritual practice? ☐ Yes ☐ No Type of practice/religion: How important is spirituality in your daily life? Not important 1 2 3 4 5 6 7 8 Very important How important is religion in your daily life? Not important 1 2 3 4 5 6 7 8 Very important	Do you spend time outside? ☐ Yes ☐ No
Energy/Fatigue Level: ☐ I have abundant energy. ☐ I have adequate energy to do what I need/want to do. ☐ I could use a little more energy. ☐ I feel tired often. ☐ I feel tired all the time.	If you could change 3 things about yourself, what would they be? 1. 2. 3.
Do you exercise? ☐ Yes ☐ No Please describe (Activity and hours/week):	Please describe 2-3 of your greatest strengths and/or achievements.
On a scale from 1 to 10, where 0 is a thoroughly easy going person and 10 is a very high strung person, please rate how you generally consider yourself. _____ How do you think others would rate you? _____	Please list main interests/hobbies.
Please identify the 3 biggest stressors in your life: 1. 2. 3.	What do you do creatively? / What are your creative outlets?

XVI. Dietary Habits

Please describe your dietary habits: Breakfast:	Do you have food allergies/intolerances? ☐ Yes ☐ No Please describe:
Lunch:	Do you experience food cravings? ☐ Yes ☐ No For what types of food?
Dinner:	Recent improvements to your diet include:
Snacks:	What are the factors in your life that interfere with eating better?

How many glasses of water/day do you drink? _____ Is it filtered water? ☐ Yes ☐ No	How many cups of coffee per day do you drink? What type: _____
How many cans of soda or juice/day do you drink? _____ Diet: ☐ Yes ☐ No What type: _____	How many cups of tea/day do you drink? _____ What type? ☐ Black ☐ Green ☐ Other: _____
What % of your weekly food intake is organic? _____	What % of your weekly meals are home-prepared?
How many meals do you eat out/week on average? _____	Do you cook? ☐ Yes ☐ No
My diet can best be described as: ☐ Omnivore (Meats/poultry/fish/eggs/dairy/fruits/grains/veggies) ☐ Semi-vegetarian (I include some animal products, specifically: ☐ Ovo-lacto-vegetarian (I exclude animal flesh, but include dairy and eggs.) ☐ Vegan (I exclude all animal products.) ☐ Other (please explain)	Regarding the way you eat, which statement most closely describes you: ☐ I am not considering any nutritional changes at this time. ☐ I am considering nutritional changes, but am not ready to make changes. ☐ I am early into the process of making nutritional changes. ☐ I am well into the process of making nutritional changes. ☐ I am maintaining prior changes that I have implemented.
Anything else you would like to say about your diet?	My interest and motivation to make/sustain changes is: None Slight Moderate Strong Very Strong My confidence in my ability to make/sustain changes: None Slight Moderate Strong Very Strong

XVII. Toxic Exposure History

Did you grow up near a refinery, polluted area or in a house with lead paint? Please explain: _____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? Please explain: _____
Have you ever had health problems when you put in new carpeting/cabinets, painted your home, or did other refurbishing? Please explain: _____
Are you particularly sensitive to perfumes, cleaners, gasoline or other vapors? Please explain: _____
Do you use herbicides, pesticides, or other chemicals around your home? Please explain: _____

XVIII. Complementary Care History

Please indicate each type of complementary care that you have tried or that interests you. Please list others if not listed.

Acupuncture: ☐ Interested ☐ Tried ☐ Helpful	Lifestyle Counseling/ Stress Management: ☐ Interested ☐ Tried ☐ Helpful	Hypnotherapy: ☐ Interested ☐ Tried ☐ Helpful
Chiropractic: ☐ Interested ☐ Tried ☐ Helpful	Hydrotherapy: ☐ Interested ☐ Tried ☐ Helpful	Reiki: ☐ Interested ☐ Tried ☐ Helpful
Homeopathy: ☐ Interested ☐ Tried ☐ Helpful	Mind-Body Medicine ☐ Interested ☐ Tried ☐ Helpful	Yoga: ☐ Interested ☐ Tried ☐ Helpful
Naturopathic Medicine: ☐ Interested ☐ Tried ☐ Helpful	Meditation: ☐ Interested ☐ Tried ☐ Helpful	Chinese Herbs: ☐ Interested ☐ Tried ☐ Helpful
Nutritional Counseling: ☐ Interested ☐ Tried ☐ Helpful	Guided Imagery: ☐ Interested ☐ Tried ☐ Helpful	Western Herbs: ☐ Interested ☐ Tried ☐ Helpful
Massage Therapy: ☐ Interested ☐ Tried ☐ Helpful	Spiritual Direction: ☐ Interested ☐ Tried ☐ Helpful	Environmental Medicine: ☐ Interested ☐ Tried ☐ Helpful
Other:	Other:	Other: