Peak Health Through Traditional Wisdom

Name _____ Date of First Visit _____

Address _____ City/State/Zip _____

Telephone Preference #1 _____ #2 _____

Can we leave a voice message? Yes _____ No _____

Age _____ Date of Birth _____ Gender _____

Education _____

Married _____ Separated ____ Divorced _____ Widowed ____ Single _____ Partnership ____

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____ Alone ____

Occupation _____ Hours per week _____ Retired _____

How did you hear about our clinic? _____

Next of Kin or other to reach in an emergency _____

Relationship _____ Phone _____

Your Email _____

Can we contact you at this email? Yes _____ No _____

Would you like to receive our newsletter by email? Yes _____ No thanks _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE.

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN 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.

Are you currently receiving healthcare or mental healthcare? **Y N**

If yes, where and from whom? _____

For what condition? _____

Do you have any known contagious diseases at this time? **Y N** If yes, what? _____

What are your most important health problems? List as many as you can in order of importance.

1 _____

2 _____

3_____

4_____

5_____

How does your condition(s) affect you? _____

_____

_____

What do you think is happening? _____

_____

What do you feel needs to happen for you go get better? _____

_____

What do you enjoy most in your life? _____

_____

How much change are you willing to make at this time for improving your health?

MINIMAL SOME COMPLETE

What hospitalizations or surgeries have you had?

_____ date: _____ _____ date: _____

_____ date: _____ _____ date: _____

Allergies

Are you hypersensitive or allergic to any:

Drugs _____

Foods _____

Enviromentals _____

Medications and Supplements

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

Name	**Dose**	**Name**	**Dose**
1		4	
2		5	
3		6	
7		8	

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

For all the following sections,

Y = a condition you have NOW **N** = Never Had **P** = a condition you have had before

Lifestyle Habits

Main interests and hobbies? _____

Do you exercise? **Y N** If yes, what kind? _____

Average 6-8 hours of sleep per night? **Y N** Sleep well? **Y N** Awaken rested? **Y N**

When during the day is your energy the Best? _____ Worst? _____

Have a supportive relationship(s)? **Y N**

Have a history of abuse? **Y N**

Any major traumas? **Y N**

Use recreational drugs? **Y P N**

Been treated for drug dependence? **Y P N**

Use alcoholic beverages? **Y P N**

Treated for alcoholism? **Y N**

Do you use tobacco? **Y P N**

If smoked previously Number of years _____ packs per day _____

Do you eat three meals a day? **Y N**

Do you eat out often? **Y N**

Do you go on diets often or have a history of disordered eating? **Y N**

Do you drink coffee? **Y N**

Do you drink cola or other sodas? **Y N**

Do you enjoy your work? **Y N**

Take Vacations? **Y** **N**

Spend time outside? **Y** **N**

Do you have a spiritual practice? **Y** **N** If yes, what? _____