Chesapeake Holistic Health

HEALTH HISTORY

Name: _____DOB: _____ Date: _____

Occupation: _____ Weight: _____ Height: _____Gender: _____ Number of Children:_____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu?_____ Are you pregnant? _____

Referred by: _____

List of current health problems for which you are being treated: _____

_____

Reason for initial visit: _____

Name of GP/Specialists: _____

What types of therapies have you tried for these problem(s) or to improve your health overall:
☐ diet modification ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ massage ☐ acupuncture ☐ OTC/prescription drugs
☐ other _____

Do you experience any of these general symptoms on a regular basis?

☐ allergies	☐ depression	☐ food cravings	☐ intolerance to extreme temperatures	☐ skin issues
☐ bruising	☐ diarrhea	☐ gas/bloating	☐ irritated bowel	☐ urinary incontinence
☐ chronic pain/inflammation	☐ disinterest in sex	☐ hair loss	☐ nausea	☐ vomiting
☐ constipation	☐ dizziness	☐ headaches	☐ panic attacks	☐ water retention
☐ cough	☐ fatigue	☐ insomnia	☐ shortness of breath	

Current prescription or over-the-counter medications: ***(Please bring them with you to your appointment)***: _____

_____

Please bring any lab work from within the last 12 months including blood, urine, saliva, and hair analysis.

Major hospitalizations, surgeries, injuries: *(Please list all procedures, complications (if any) and dates)*:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., family, changes in job/work, residence or finances, legal problems):_____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, etc.)? _____

What are your current health goals: _____

Medical History

☐ Arthritis
☐ Allergies/Hay fever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
Other _____

Medical (Men)

☐ Benign prostatic hyperplasia
☐ Prostate cancer
☐ Decreased sex drive
☐ Erectile Dysfunction
☐ Sexually transmitted disease
Other _____

Medical (Women)

☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
Other _____
Date of last GYN exam _____
Form of birth control _____
# of children _____
# of pregnancies _____
☐ C-Section
Age of first period _____
Date-last menstrual cycle _____
Length of cycle (days) _____
Interval of time between cycles (days) _____
Any recent changes in normal menstrual flow (e.g., heavier, large clots, light) _____
☐Surgical menopause
☐Menopause

Family Health History (Parents and Siblings)

☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
Other _____

Health Habits

☐ Tobacco:
Cigarettes: #day _____
Cigars: #day _____
☐ Alcohol:
Wine: #glasses day/wk _____
Liquor: #ounces day/wk _____
Beer: #bottles day/wk _____
☐ Caffeine:
Coffee: #6 oz cups/day _____
Tea: #6 oz cups/day _____
Soda w/caffeine: #cans/day ____
Other sources _____
☐ Water: #glasses/day _____

Exercise

☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45 minutes or more duration per workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Walk - #days/wk _____
☐ Run, jog, other aerobic - #days/wk _____
☐ Weight lift - #days/wk _____
☐ Stretch (Yoga) - #days/wk ___
Other _____

Nutrition & Diet

☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ Total calorie restriction
Specific food restrictions:
☐ dairy ☐ gluten ☐ eggs
☐ soy ☐ corn ☐ nuts
Other _____

Food Frequency

Number of servings per day:
Fruits (citrus, melons, etc)_____
Dark green or deep yellow/orange vegetables _____
Grains _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____
Desserts/Sweets _____

Eating Habits

Skip meals – which ones _____
☐ One meal/day
☐ Two meals/day
☐ Three meals/day
☐ Graze (small frequent meals)
☐ Generally eat on the run
☐ Eat constantly whether hungry or not

Current Supplements

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin D
☐ Vitamin E
☐ EFA/Fish Oil
☐ Calcium
☐ Magnesium
☐ Iron
☐ Minerals, describe _____
_____
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Antioxidants (e.g., lutein, resveratrol, etc.)
Other _____
_____

I would like to:

Energy-Vitality

☐ Feel more vital
☐ Have more energy
☐ Have more endurance
☐ Be less tired after lunch
☐ Sleep better
☐ Be free of pain
☐ Get fewer colds and flu
☐ Get rid of allergies
☐ Not be dependent on over-the-counter medications
☐ Stop using laxatives and stool softeners
☐ Improve sex drive

Body Composition

☐ Lose weight
☐ Burn more body fat
☐ Be stronger
☐ Have better muscle tone
☐ Be more flexible

Stress, Mental, Emotional

☐ Learn how to handle stress
☐ Think more clearly and be more-focused
☐ Improve memory
☐ Be less depressed
☐ Be less moody
☐ Be less indecisive
☐ Feel more motivated

Life Enrichment

☐ Reduce my risk of degenerative disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer
☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

Signed Disclaimer ☐