Healing Axis

Integrative Energy Medicine

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Health History Questionnaire

Please help me to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you for taking the time to fill this out form thoughtfully. Bring this four page form with you to your first appointment.

Name:________________________________ Age _____ Birth Date _________ Sex: M / F

Address_____________________________________ City________________________ Zip Code___________

Cell Phone___________________ Work Phone_________________ Home Phone______________________

Emergency Contact ______________________________________ Phone________________________________

E-Mail:_____________________________________ Can we send you health newsletter via e-mail? Yes □ No □

Family Physician____________________________ Referred by__________________________________

Current Health Concerns

Please list your health concerns. Begin with the most important to address today.
Classify your health concern as: 1= Minor **2 =** Moderate **3 =** Fairly severe and getting worse **4 =** Serious

	Classified As	Date of Onset
1. ____	_________	________________
2. ____	_________	________________
3. ____	_________	________________

To What extent do these problems interfere with your daily activities (work, sleep, range of movement, sex) ?
____
____

What kind of treatments have you tried? Acupuncture? yes□ no□ other:____
____

Please list some of the most *notably* significant events in your life beginning with the most recent. (E.G. marriage/divorce, accidents, career change, deaths of loved ones, residency changes etc.)
1.____
2.____
3.____
4.____

What kind of concerns do you have regarding your current health situation? Check all that apply.
_______ 1. I would like to have relief from my symptoms or pain.
_______ 2. I would like to alleviate as much as possible the tendencies which cause my condition.
_______ 3. I would like to be holistically balanced as much as possible, including body, mind and spirit.
_______ 4. I would like "tune-up" or maintenance care to proactively keep in optimum health.

General Information

Yes	No		Yes	No	
☐	☐	Do you have diabetes?	☐	☐	Do you have hepatitis, cancer or HIV?
☐	☐	Do you bruise easily?	☐	☐	Have you recently traveled outside US?
☐	☐	Do you bleed for a long time from a cut?	☐	☐	Have you ever been treated for emotional problems
☐	☐	Do you have a tendency to faint?	☐	☐	Have you ever considered or attempted suicide?
☐	☐	Are you nervous about needles?	☐	☐	Do you have lymph edema?
☐	☐	Are you generally very tired?	☐	☐	
☐	☐	Do you have high blood pressure?	☐	☐	
☐	☐	Do you have a pacemaker or other electronic device in your body? ________	☐	☐	

Personal Health Habits

Yes	No		
☐	☐	Smoker	Smoked for _____ years. Smoke _______ pack(s) per day currently. If stopped, year: _____
☐	☐	Alcohol	Type____ Frequency __________
☐	☐	Recreational Drugs	Type ____ Frequency __________
☐	☐	Coffee	Cups per day ________ Water drink per day: ____________
☐	☐	Regular Exercise	If so, describe type and frequency____

Height __________ Current Weight _________ lbs. Weight 1 year ago: _________ lbs.

Stress: What do you currently find most stressful? ____
____
____

Daily Diet: Please describe your average daily diet:

Morning____

Lunch ____

Evening____

Snacks ____

Sleep: How many hours per night? ________ Do you dream, if so how often? _____________________ Nightmares?_____

Do you fall a sleep easily? **Yes / No** Do you wake up often? **Yes / No** Any specific time(s)?_________________________

Energy: Are you happy with your level of energy? **Yes / No** My energy is highest at what time of day? __________

It is lowest at what time? ______________ On a scale of 1-10, (10 very high) what is your energy? __________

Hospitalization/ Accidents

Please list any hospitalizations, surgery, serious injuries, and recent dental work with a short description and date.

____

____

____

____

____

Current & Former Conditions

☑ Check mark any of the following that you are experiencing now or have experienced in the past 3 months.

General Symptoms

- ☐ Headache or migraine
- ☐ Feel warmth a lot
- ☐ Feel cool a lot
- ☐ fatigue
- ☐ abnormal sweating
- ☐ dizziness/ tremors
- ☐ convulsions
- ☐ decreased motivation
- ☐ difficulty concentrating
- ☐ poor memory
- ☐ decreased libido
- ☐ night sweats
- ☐ poor balance
- ☐ edema Where?_______
- ☐ chills

Skin & Hair

- ☐ rashes
- ☐ itching
- ☐ change in hair or skin
- ☐ dry skin
- ☐ clammy skin
- ☐ hair loss
- ☐ other hair/skin problems

____

Head, Ears, Nose & Throat

- ☐ facial pain
- ☐ glasses/ contacts
- ☐ floaters
- ☐ night blindness
- ☐ blurry vision
- ☐ eye pain
- ☐ eye strain
- ☐ cataracts
- ☐ eye dryness
- ☐ excessive tearing
- ☐ eye inflammation
- ☐ Discharge from eyes
- ☐ poor hearing
- ☐ ringing in ear
- ☐ earaches
- ☐ discharge form ears
- ☐ nasal congestion
- ☐ sneezing
- ☐ Hay fever/ allergies
- ☐ asthma
- ☐ loss of taste
- ☐ recurrent sore throat
- ☐ nose bleeds
- ☐ TMJ
- ☐ tooth or gum problems
- ☐ teeth grinding
- ☐ frequent cold sores
- ☐ sores on lips or tongue

Respiratory

- ☐ cough
- ☐ pain with a deep breath
- ☐ difficulty breathing while lying down
- ☐ Production of phlegm What color?_______________
- ☐ coughing blood
- ☐ bronchitis
- ☐ other Lung problems:

____

____

Gastrointestinal

- ☐ bad breath
- ☐ nausea
- ☐ vomiting
- ☐ heartburn
- ☐ belching
- ☐ indigestion
- ☐ constipation
- ☐ chronic laxative use
- ☐ blood in stools
- ☐ black stools
- ☐ abdominal cramps or pain
- ☐ diarrhea
- ☐ gas
- ☐ rectal pain
- ☐ hemorrhoids
- ☐ other stomach or intestinal problems___________________
- ☐ bloating

Cardio-Vascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chest discomfort or pain
- ☐ cold hands or feet
- ☐ swelling in: ☐ hands or ☐ feet
- ☐ blood clots
- ☐ fainting
- ☐ palpitations
- ☐ irregular heartbeat

Genito-Urinary

- ☐ pain on urination
- ☐ urgency to urinate
- ☐ frequent urination
- ☐ blood in urine
- ☐ decrease in flow
- ☐ unable to hold urine
- ☐ dribbling
- ☐ kidney stones
- ☐ impotency
- ☐ sores on genitals
- ☐ wake to urinate. How often?__________________
- ☐ history of STD's
- ☐ abundant pale urination

Musculoskeletal

- ☐ Joint Pain/ Stiffness indicate specific areas on page 4.
- ☐ Muscle weakness
- ☐ Bone problems
- ☐ Arthritis

Neurological

- ☐ spasms
- ☐ numbness or tingling
- ☐ paralysis

Emotions

- ☐ irritability/anger
- ☐ depression
- ☐ anxiety
- ☐ Mood swings
- ☐ fear
- ☐ chronic worry
- ☐ excessive grief

Female Issues

- ☐ pregnancies_____births_______
- ☐ premature births
- ☐ miscarriages
- ☐ stillborn/ abortions__________
- ☐ first menses: age_______
- ☐ last PAP ______________
- ☐ duration of menses
- ☐ days between menses
- ☐ painful menstrual periods
- ☐ clots
- ☐ excessive or light flow
- ☐ cramps or headaches
- ☐ vaginal discharge
- ☐ breast soreness
- ☐ endometreosis
- ☐ irregular menstruation
- ☐ uterine fibroids
- ☐ peri or post menopause

Medications/Vitamins/Supplements

Please list all your medications or provide a list. Include sleeping pills, birth control agents and non-prescription drugs that you use on a regular basis (e.g. aspirin, laxatives, antihistamines, antacids).

____
____
____
____

Please list all your vitamins and supplements you are taking on a regular basis.

____
____

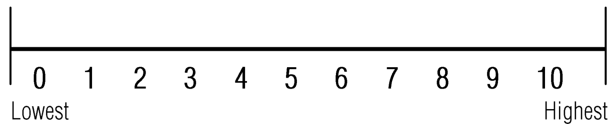
Please list all herbs you are taking on a regular basis.

____
____

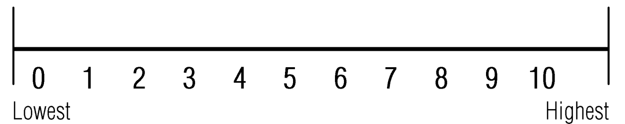
Family History:

□ Cancer	□ Heart Disease	□ Mental Illness	□ Thyroid disease
□ Diabetes	□ Stroke	□ MS	□ Glaucoma
□ Hepatitis	□ Seizures	□ Asthma	□ Tuberculosis
□ High Blood Pressure	□ Depression	□ Autoimmune Disease	□ Kidney disease

Please note the degree of severity of your problem now:



Please note the greatest degree of severity of your problem within this past week:



Please indicate painful or distressed areas below.