HEALTH INVENTORY

(This information is confidential and will only be released with your signed consent.)

Name: _____ Today's Date: _____

Address: _____ Birth Date: _____

_____ Age: _____ Sex: _____

Phone: H _____ C_____ W _____

Email address: _____

Legal Status: □ Single □ Married □ Divorced □ Separated □ Widow/er

Education (yrs completed): Elem ___ HS ___ Coll ___ Voc ___ Prof ___

Occupation: _____ Retired: □ Yes □ No □ Semi

Emergency contact: _____ Phone: _____

If under 18, parents' name and address: _____

Referred by name and address: _____

Family physician name and address: _____

FAMILY HISTORY

□ *Check here if family history is unknown*

	Age	If deceased, cause of death
Father		
Mother		
Siblings		
"		
"		
"		
"		
"		
"		
"		

Children	Age	Health Problems

Yes	Blood relative
□ Alcohol/drug problem	_____
□ Allergy/asthma	_____
□ Anemia	_____
□ Arteriosclerosis	_____
□ Arthritis	_____
□ Bleeding problem	_____
□ Cancer	_____
□ Diabetes	_____
□ Epilepsy/seizure	_____
□ Endocrine/hormonal	_____

Yes	Blood relative
□ Gastrointestinal	_____
□ Gonorrhea/syphilis	_____
□ Heart disease	_____
□ High blood pressure	_____
□ High cholesterol	_____
□ Kidney/Liver disease	_____
□ Mental illness	_____
□ Stroke	_____
□ Suicide	_____
□ Tuberculosis	_____

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: list all surgery and approximate dates

_____ _____
_____ _____
_____ _____

Other hospitalizations and dates

_____ _____
_____ _____
_____ _____

Broken bones and/or traumatic injuries
(include all car accidents or concussions)

_____ _____
_____ _____
_____ _____

Current health problems
Example: high blood pressure 10 yrs

_____ _____
_____ _____
_____ _____

YES	WHEN	YES	WHEN	YES	WHEN
☐ Acne	_____	☐ Epilepsy	_____	☐ Pelvic infection	_____
☐ AIDS	_____	☐ Epstein Barr/infectious mono	_____	☐ Peptic ulcer	_____
☐ Alcohol/drug problem	_____	☐ Fibrocystic breasts	_____	☐ Periodontal disease	_____
☐ Allergies	_____	☐ Fibroids	_____	☐ Phlebitis	_____
☐ Anemia	_____	☐ Gallbladder problem	_____	☐ Pneumonia	_____
☐ Antibiotics more than once a year	_____	☐ Glaucoma	_____	☐ Premenstrual tension	_____
☐ Anorexia	_____	☐ Gonorrhea	_____	☐ Prostate problem	_____
☐ Anxiety	_____	☐ Gout	_____	☐ Psychotherapy	_____
☐ Arteriosclerosis	_____	☐ Hay fever	_____	☐ Reactions to vaccinations	_____
☐ Arthritis	_____	☐ Hearing problem	_____	☐ Rheumatic fever	_____
☐ Asthma	_____	☐ Heart attack	_____	☐ Root canal	_____
☐ Back pain/strain	_____	☐ Heart failure	_____	☐ Scarlet fever	_____
☐ Binge eating	_____	☐ Heart problem	_____	☐ Sexually transmitted disease	_____
☐ Bladder infection	_____	☐ Hemorrhoids	_____	☐ Sinusitis	_____
☐ Blood clots	_____	☐ Hepatitis	_____	☐ Skin problem	_____
☐ Breast lump	_____	☐ Herpes	_____	☐ Sleep disorder	_____
☐ Bronchitis	_____	☐ Hiatal hernia	_____	☐ Stroke	_____
☐ Bulimia (self-induced vomiting)	_____	☐ High blood pressure	_____	☐ Suicide attempt	_____
☐ Cancer	_____	☐ High chol/tri	_____	☐ Syphilis	_____
☐ Cataract	_____	☐ Hives	_____	☐ Taken steroid (cortisone/prednisone)	_____
☐ Chemical sensitivity	_____	☐ Hypoglycemia	_____	☐ Thyroid problem	_____
☐ Chicken pox	_____	☐ Insomnia	_____	☐ Tonsillitis	_____
☐ Chronic fatigue	_____	☐ Kidney infection	_____	☐ Tooth problem	_____
☐ Colds, frequent	_____	☐ Kidney stones	_____	☐ Tuberculosis	_____
☐ Colitis	_____	☐ Kidney problem	_____	☐ Urine problem	_____
☐ Congenital defect	_____	☐ Liver disease	_____	☐ Vaginitis	_____
☐ Counseling	_____	☐ Menstrual problem	_____	☐ Vision problem	_____
☐ Depression	_____	☐ Mental illness	_____	☐ Warts	_____
☐ Diabetes	_____	☐ Migraine	_____	☐ Other problem	_____
☐ Ear infection	_____	☐ Nervous condition	_____	☐ _____	
☐ Eczema	_____	☐ Neurological problem	_____	☐ _____	
☐ Endometriosis	_____	☐ Overweight (>20 lbs)	_____		
		☐ Panic attacks	_____		

REVIEW OF SYSTEMS

Circle all symptoms you have had in the last 12 months

ALL THAT APPLY:

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food craving
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hairloss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headaches
- ☐ Dizziness
- ☐ Balance problem
- ☐ Head injury
- ☐ Seizure/convulsion
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing
- ☐ Eye pain
- ☐ Dark circles under eyes
- ☐ Date last eye exam _____
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breather

ALL THAT APPLY:

- ☐ Chronic cough
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
  - ☐ with exertion
  - ☐ at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High blood pressure
- ☐ Chest pain or pressure
  - ☐ at rest
  - ☐ with exertion
  - ☐ with stress
  - ☐ with eating
  - ☐ down left arm, neck or back
  - ☐ accompanied by nausea, sweating, or anxiety
- ☐ Irregular heartbeat
- ☐ Skip beats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Joint pain
- ☐ Pain or fatigue in legs w exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Difficulty swallowing
- ☐ Pain/discomfort with eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Canker sores
- ☐ Pain relieved by eating
- ☐ Nausea/vomiting
- ☐ Trouble with fried foods
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay-colored stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding

ALL THAT APPLY:

- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Foul odor of urine
- ☐ Low back pain
- ☐ Loss of control of urine

MEN

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling or rash
- ☐ Problem with sexual function

WOMEN

Last menstruation period _____
Age began menstruation _____
Age at menopause _____
Number of pregnancies _____
Number of live births _____
Number of abortions/ miscarriages _____

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD - type _____

Usual length of cycle _____
Usual length of period _____
Date of last pap smear _____

- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility

PERSONAL HISTORY

Current medications
List all prescriptions/non-prescriptions and dosage

_____
_____
_____
_____
_____

Vitamin and mineral supplements
Type and dosage

_____
_____
_____
_____
_____

Allergies
I am allergic to the following medications:

_____
_____
_____
_____
_____

Food allergies and method of testing

_____
_____
_____
_____
_____

Lifestyle
List your favorite foods or cravings

_____
_____
_____
_____
_____

I do the following for relaxation/recreation

_____
_____
_____
_____

I am now or have been a smoker: ☐ Yes ☐ No
How many years have you smoked? _____
How much? _____
When did you quit? _____

I estimate my use of:
Coffee _____ cups/day Decaf _____ cups/day

I use: ☐ Beer ☐ Wine ☐ "hard" liquor

I consider myself a: ☐ non-drinker ☐ social drinker
☐ heavy drinker ☐ alcoholic ☐ recovering alcoholic

I use: ☐ marijuana ☐ other drugs _____

I participate in an exercise program ☐ Yes ☐ No

I exercise on a regular basis ☐ Yes ☐ No
_____ times _____ week/month

I think this is enough exercise ☐ Yes ☐ No

I would like to do more exercise ☐ Yes ☐ No

I find my work ☐ satisfactory ☐ very satisfying
☐ too demanding ☐ boring

My sex life is satisfactory ☐ Yes ☐ No

I sleep well ☐ Yes ☐ No

I worry about ☐ money ☐ job ☐ family life
☐ relationships ☐ other _____

I currently see a psychotherapist or
other mental health professional ☐ Yes ☐ No

I have had a therapeutic massage ☐ Yes ☐ No

I currently see a chiropractor, osteopath, or
other physical therapy person ☐ Yes ☐ No

I have been arrested ☐ Yes ☐ No

I have been in the military service ☐ Yes ☐ No

I have been a victim of abuse ☐ physical ☐ sexual
☐ emotional

My spiritual life is satisfactory ☐ Yes ☐ No

I am currently involved in a regular
spiritual program ☐ Yes ☐ No

My last physical exam was _____

Additional Information

Please list the three chief complaints that you would like help with:

_____
_____
_____
_____

Was there a specific time or situation when you noticed these complaints began?

_____
_____
_____
_____
_____

What aggravates the above mentioned complaints? (Ex. Time of day, year, stressors, foods)

_____
_____
_____
_____
_____

Describe a life situation that causes you to feel stressed or anxious:

_____
_____
_____
_____
_____

Any additional information about yourself that you feel this form may have missed?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____