JOANNA HEATH
WELLNESS

Health History Intake Form

This is a confidential record of your medical history. Information shared here will not be released to any person unless you have authorized us to do so. Please complete the questionnaire as thoroughly as possible. Thank you.

PERSONAL INFORMATION

Name_____
Date of birth_____ Age_____
Address:
Street_____
City_____State_____Zip code_____
Phone (day)_____(evening)_____
Occupation_____

NOTE: this is a confidential record of your medical history and will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so. Please complete the questionnaire as thoroughly as possible. Thank you.

What are the major concerns that have brought you to this office today? _____
_____
_____
_____
When did this begin? _____
_____
Has anything recently changed or become worse? _____
_____
_____
Have you had a diagnosis? If so, what was it, how was it arrived at, and by whom? _____
_____
Are you currently receiving care from any other health professional?
(Name)_____
What condition(s)?_____
Are you currently taking **any** medications, prescription or otherwise? YES_____ NO_____
Please list them: _____
_____
_____
_____
Do you have any infectious diseases that you know of? YES_____ NO_____

If yes, please list them: _____

Are you pregnant? YES_____ NO_____
If yes, how many months? _____

Do you have any known allergies or sensitivities? If so, please list them:
_____
_____
_____

Is there any reason why you could not take remedies made in alcohol?
_____

Have you ever been hospitalized or had any surgeries? If so, please note date and reason:
_____
_____
_____

FAMILY MEDICAL HISTORY
Please complete this section only for family members with particular health problems.

	Age	**Medical Problems (if any)** (If deceased, provide date and cause of death)
Father		
Mother		
Brothers/ Sisters		
Children		
Other close biological relatives		

PERSONAL HEALTH HABITS

Height _____ Current weight_____ Weight 1 year ago_____
Do you smoke? _____ How many years? _____ Amount daily_____
Do you drink alcohol? _____ What? _____ Frequency? _____
Do you use recreational drugs? _____ What? _____ Frequency?_____
Do you drink coffee? _____ How much?_____ Tea?_____ How much?____
Do you exercise regularly? ___ Frequency? _____
Type? _____ Duration?_____

HEALTH CONCERNS Check off any experienced in the last three months.

SKIN & HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in skin texture
- ☐ Poor Healing sores
- ☐ Eczema
- ☐ Hair Loss
- ☐ Other: _____
- ☐ Hives
- ☐ Pimples
- ☐ Moles

HEAD, EYES, EARS, NOSE, & THROAT

- ☐ Poor vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Cold sores
- ☐ Facial pain
- ☐ Sinus congestion
- ☐ Ear infections
- ☐ Spots in front of eyes
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Sore throat
- ☐ Grinding teeth
- ☐ Clicking jaw
- ☐ Mucous in throat
- ☐ Dizziness
- ☐ Other:
- ☐ Glaucoma
- ☐ Poor hearing
- ☐ Canker sores
- ☐ Nose bleeds
- ☐ Eye pain
- ☐ Swollen glands
- ☐ Frequent colds

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Cold hands or feet
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Other:
- ☐ Chest pain
- ☐ Palpitations

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain on breathing
- ☐ Shortness of breath without exertion
- ☐ Difficulty breathing when lying down
- ☐ Production of phlegm ☐ YES ☐ NO If yes, what color?_____
- ☐ Other:

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Hemorrhoids
- ☐ Food cravings
- ☐ Difficulty swallowing
- ☐ Vomiting
- ☐ Black stools
- ☐ Indigestion
- ☐ Mucous in stools
- ☐ Gas
- ☐ Poor appetite
- ☐ Other:
- ☐ Diarrhea
- ☐ Bad breath
- ☐ Heartburn
- ☐ Rectal pain
- ☐ Bloating
- ☐ Food allergies

# of bowel movements daily _____ ☐ Loose ☐ Normal ☐ Hard?

URINARY

- ☐ Painful urination
- ☐ Urinary urgency
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Inability to hold urine
- ☐ Blood in urine
- ☐ Irregular flow
- ☐ Decreased flow
- ☐ Difficulty starting/stopping slow
- ☐ Other: _____

MUSCULOSKELTEAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Stiffness
- ☐ Reduced range motion
- ☐ Other: _____

Do you see a chiropractor or massage therapist? (name) _____

REPRODUCTIVE
Age at first menses: _____
Length of cycle: _____
Duration of bleeding: _____

- ☐ Heavy bleeding
- ☐ Pain with intercourse
- ☐ Unusual bleeding
- ☐ Cramps
- ☐ Discharges
- ☐ Irregular cycles
- ☐ Breast lumps
- ☐ Clots

PMS? If yes, what symptoms? _____
_____
_____
_____
_____

Date and result of last pap
smear_____

REPRODUCTIVE (continued)

# of pregnancies _____
Premature births _____

# of births _____
Abortions _____
# of Miscarriages _____
Onset of menopause _____

Type of birth control
used_____
_____
Any other gynecological problems? _____
_____
_____

NEUROPSYCHOLOGICAL

- ☐ Poor sleep
- ☐ Depression
- ☐ Seizures
- ☐ Headaches
- ☐ Lack of coordination
- ☐ Other:
- ☐ Poor memory
- ☐ Irritability
- ☐ High stress levels
- ☐ Difficulty concentrating
- ☐ Loss of balance
- ☐ Numbness
- ☐ Anxiety
- ☐ Migraine
- ☐ "Spacey"/foggy feeling

Hours of sleep per 24 hours: _____

GENERAL

- ☐ Fatigue
- ☐ Night sweats
- ☐ Slow metabolism
- ☐ Other:
- ☐ Fevers
- ☐ Excessive thirst
- ☐ Intolerance to heat/cold
- ☐ Chills
- ☐ Sudden energy drops

MEDICATIONS & SUPPLEMENTS

Please list all of the pharmaceutical drugs, over-the-counter medications, supplements, nutritional drinks, and herbal supplements you have used *in the past six (6) months*. Use additional pages or bring these items with you to the consultation if you prefer.

	Currently		Dose, Form, Frequency*	What condition do you take this for?	Are you happy with the effects? Do you experience any side effects?
	Y	N			
Prescription Medications					
Over-the-Counter Medications (e.g., antacids, laxatives, aspirin, Tylenol, Advil, Motrin, Aleve, cough drops, cough					
Vitamin/Mineral Supplements or Nutritional Drinks (e.g., energy drinks, protein shakes, etc.)					
Herbal Supplements (please list all herbs included if a formula)					

*DOSE is how many milligrams or units; FORM is capsule, tablet, powder, liquid, etc.; FREQUENCY is how many times per day you take it.