Office use only: Clinician_____ Account Number:_____

## CONFIDENTIAL CLIENT HEALTH HISTORY

Client Name: _____ Date of Birth: _____ Today's Date: _____

Personal Physician: _____ Date of most recent physical exam: _____

Physician Address: _____ Phone Number: _____

Are you currently under the care of additional doctors/hospitals/health facilities? ❒ Yes ❒ No

If yes, who and where? _____

Current health status: ❒ Good ❒ Fair ❒ Poor

**Do you take medication on a daily basis (pills, shots, other)?** ❒ Yes ❒ No

| **Medication:** (name and dosage) | **Reason For Use** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

| **Allergies:** Type (medication, food, environmental) | **Reaction** |
|---|---|
| 1. | |
| 2. | |
| 3. | |

| **Have the following changed for you in the last year?** | **NO** | **YES - Explain** |
|---|---|---|
| Appetite | | |
| Weight | | |
| Sleeping Habits | | |
| Energy Level | | |

**Do any of these changes interfere with your daily life?**

| **Do you…?** | **NO** | **YES – How often?** |
|---|---|---|
| Exercise | | |
| Use tobacco, nicotine, smoke, vape | | |
| Drink Caffeine (coffee, tea, soda, energy drinks, etc.) | | |
| Drink Alcoholic Beverages | | |
| Use illegal substances (marijuana, cocaine, etc.) | | |
| Surf the internet for recreation/watch tv | | |
| Play electronic /video games | | |

**Do any of these activities interfere with your daily life?**

**(OVER → →)**

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| **Have you ever had any of the following illnesses or symptoms? (Please add detail in comment section below)** | | | | | |
|---|---|---|---|---|---|
| **Illnesses/Symptoms** | **No** | **Yes** | **Illnesses/Symptoms** | **No** | **Yes** |
| Diabetes | | | Persistent Fatigue | | |
| Thyroid/Gland Problems | | | Sleep Difficulties | | |
| Head Injury | | | Obesity | | |
| Seizures/Epilepsy | | | Eating Disorder (Anorexia/Bulimia) | | |
| Blackouts/Fainting/Dizzy Spells | | | Hepatitis/Jaundice | | |
| Stroke | | | Stomach Problems | | |
| Heart Disease/Rapid Heart Beat | | | Kidney/Bladder/Bowel Problems | | |
| High Blood Pressure | | | Infertility | | |
| Low Blood Pressure | | | Sexual Problems | | |
| Cancer | | | Excessive Bleeding Internally/Externally | | |
| Asthma | | | High Cholesterol | | |
| Frequent Infections | | | Hearing Loss/ Ringing in Ears | | |
| Operations/Surgery | | | Blurred Vision | | |
| Liver Problems | | | Skin Disorder | | |
| Recurrent Headaches | | | Anemia/Blood Disorders | | |
| Arthritis | | | Tuberculosis | | |
| Breathing/Lung Problems | | | Other: | | |

**Comments about illnesses/symptoms:**

| **OB/GYN** | **No** | **Yes** | | **No** | **Yes** |
|---|---|---|---|---|---|
| Currently Pregnant | | | Gynecological Problems (Infections, Surgery, etc.) | | |
| Pregnancy Loss | | | Hormones | | |
| Menopause | | | Number of Live Births | | |
| Menstrual Problems | | | | | |

**Do you have any physical limitations?**

**Is there any family history of significant health issues? ❒ Check here if you are adopted.**

**Is there additional information about your health that you would like us to know?**

_____

**Office Only**

**Reviewed By_____ Date_____ Signature_____**