**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, Smoke |  |  |
| 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 → →)**

|  |
| --- |
| **Do you now or have you ever had any of the following illnesses or symptoms? (Please add detail in comment section below)** |
| **Illnesses/Symptoms** | **No**  | **Yes** | **Current** | **Illnesses/Symptoms** | **No** | **Yes** | **Current** |
| 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: |  |  |  |

**Please comment on illnesses/symptoms: (When did they begin? How often they occur? How intense are the 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?**

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**Office Only**

**Reviewed By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**