HEALTHY HISTORY QUESTIONNAIRE

Please help us 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. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the Comments section. **Thanks!**

Name: ________________________________ Phone: ____________Cell:____________
Address:_________________________ City: ____________ State: ______ Zip: _______
Email Address: ____
Date of Birth: ____________ Place of Birth: ________________ Marital Status:________

Employer: ____________________________ Occupation: _________________________
Family Physician: ______________________ Referred by: _________________________
In Emergency Contact (name): __________________ Emergency Phone: ________________
Preferred Method of Contact: Phone _____ Cell _____ Email _____

Have you ever been treated with Acupuncture? Y ___ N ___ Herbal Medicine Y ___ N ___

Main Problem(s) you would like help with: ____
____

How long ago did this problem begin? ____
____

How does this problem interfere with your daily activities (work, sleep, sex): _______________
____

Have you been given a diagnosis for this problem? If so, what: ________________________
____

What kinds of treatment have you tried: ____
____

Your past medical history (please include date): Cancer ____________ Diabetes __________
Hepatitis _____________ High Blood Pressure ______________ Heart Disease/Attack_____
Rheumatic Fever ____________ Thyroid Disease ______________ Seizures ____________
Venereal Disease ____________ Stroke ___________ Other_______________________

Surgeries (type and date): ____
____

Significant Trauma (auto accidents, falls, etc.): ____________________________________
____

Your birth history (prolonged labor, forceps deliver, etc.) _____________________________
____

Allergies (drugs, chemicals, foods, reaction): ______________________________________
____

Family Medical History (Check): Diabetes ____ Allergies ____ Seizures ____ Heart Disease ___
High Blood Pressure ____ Stroke ____ Asthma ____ Cancer ____
Other ____
Are you currently taking any steroids? Yes ___ No ___
Medications taken within the last two months (drugs, herbs, vitamins, etc): ________________
____

Do you have a regular exercise program? Yes ___ No ___ Please describe: _______________
____

Have you ever been on a restricted diet? Yes ___ No ___ What kind? ___________________
____

Are you currently pregnant? Yes ___ No ____

PLEASE DESCRIBE YOUR AVERAGE DAILY DIET
Morning: ____
Afternoon: ____
Evening: ____
How many packs of cigarettes do you smoke per day? _____
How much coffee, tea, or cola do you drink per week? _____
How much alcohol do you drink per week? _____

PLEASE CHECK ANY YOU HAVE HAD IN THE LAST 3 MONTHS

GENERAL
___Chills
___Fevers
___Sweat easily
___Night sweats
___Cravings
___Change in appetite
___Weight gain
___Weight loss
___Poor sleeping
___General fatigue
___Sudden drop of energy

SKIN AND HAIR
___Rashes
___Itching
___Change in hair or skin
___Eczema
___Oozing on skin lesion
___Dry skin, nails or hair
___Hives
___Pimples
___Loss of hair
___Dandruff
___Slow wound healing
___Easy bruising
___Chronic Infections
___Other hair or skin problems
____

RESPIRATORY
___Cough
___Persistent cough
___Asthma/Wheezing
___Shortness of breath
___Frequent common colds
___Pain with a deep breath
___Difficulty breathing when lying down
___Production of phlegm
What color: ____________________
___Coughing up blood
___Pneumonia
___Bronchitis
___Pleurisy
___Emphysema
___Tuberculosis

EARS, NOSE AND THROAT
___Dizziness
___Migraines
___Headaches
When: __________
Where: __________
___Sinus problems
___Hayfever
___Frequent allergies
___Facial pain
___Glasses/contacts
___Poor vision
___Color blindness
___Spots in front of eyes
___Eye pain/strain
___Cataracts
___Glaucoma
___Eye dryness
___Excessive tearing
___Discharge from eyes
___Poor hearing
___Ringing in ears

___Earaches
___Discharge from ear
___Nose bleeds
___Sinus congestion
___Nasal Drainage
___Grinding teeth
___Teeth problems
___TMJ/Jaw problems
___Concussions
___Recurrent sore throats
___Hoarseness
___Sores on lips or tongue
Other head or neck problems
____
____

CARDIOVASCULAR

___High blood pressure
___Low blood pressure
___Bleed or bruise easily
___Peculiar tastes or smell
___Strong thirst (hot or cold)
___Thirst, no desire to drink
___Fatigue
___Chest discomfort/pain
___Heart palpitations
___Cold hands or feet
___Swelling of hands or feet
___Varicose veins
___Blood clots
___Fainting
___Difficulty breathing
___Pacemaker
Other heart or blood vessel problems:
____

GASTROINTESTINAL

___Bad breath
___Nausea
___Vomiting
___Heartburn
___Belching
___Indigestion
___Stomach ulcers
___Changes in appetite
___Diarrhea
___Irritable bowel syndrome
___Constipation
___Chronic laxative use
___Blood in stools
___Black stools
___Abdominal pain or cramps
___Gas
___Rectal pain
___Hemorrhoids
___Gall Bladder disease
___Gall Bladder stones

GENITO-URINARY

___Pain on urination
___Urgency to urinate
___Frequent urination
___Blood in urine
___Decrease in flow
___Unable to hold urine
___Dribbling
___Incontinence
___Kidney stones
___Impotency
___Change in sexual drive
___Sores on genitals
___Frequent UTI
___Edema
___Do you wake to urinate?
Yes__ No__
How often?
____
What is the color of your urine?
____
___Kidney disease
___Kidney stones

MUSCULO-SKELETAL

Check all areas of pain
___Neck
___Shoulder
___Back
___Elbow
___Hand/wrist
___Hip
___Knee
___Foot/ankle
___Osteoporosis/penia
___Muscle spasm/cramps
___Muscle weakness

Other: ________________

NEUROPYSCHOLOGICAL

___Seizures
___Areas of numbness/tingling
___Weakness
___Sleep disorders/Insomnia
___Concussion
___Vertigo/Dizziness
___Loss of coordination
___Loss of balance
___Poor balance
___Tremors
___Seizures
___Epilepsy
___Paralysis
___Dyslexia
___Poor memory
Other neurological problems?
____
____

EMOTIONAL/MENTAL

___Anxiety/fear
___Anger/frustration
___Grief/sadness
___Lack of Joy/Mania
___Worry/Over-thinking
___Clinical depression
___Mild depression
___ADD or ADHD
___Panic Attacks
___Bad temper
___Loss of control/violence
___Substance abuse

Have you ever been treated for emotional problems?
____
Have you ever considered or attempted suicide? Yes ___ No___

If you answered yes are you now? Yes ___ No ___

OTHER

___Alzheimer's
___Dementia
___Cancer
Type: _______________
___Fibromylagia
___Lupus
___Candida
___Anemia
___Rashes
___Eczema/Hives
___Hemophelia
___Hypothyroid
___Hypoglycemia
___Hyperthyroid
___Diabetes type I
___Diabetes type II
___Significant trauma
Type:________________
___Significant dental work
Type:________________
___Alcoholism
___AIDs/HIV
___Childhood illnesses
    ___Chicken pox
    ___Measles
    ___Mumps

MEN ONLY

___Impotence
___Testicular pain/
Redness/Swelling
___Low libido
___Vasectomy
Date: ______________
___Seminal emissions
___Excessive libido
___Prostate problems
___Painful intercourse

PREGNANCY AND GYNECOLOGY

Are you pregnant now? ___
Trying? _______
Do you practice birth control?
Yes ___ No___
What type and how long?
____
___Number of pregnancies
___Number of births
___Premature births
___Miscarriages
___Abortions

___Age at first menses
_______First date of last menses
___Period between menses
___Duration
___Unusual character (heavy/light)
___Painful periods
___Irregular periods
___Infertility
___Changes in body/psyche prior to menses
___Inter-cycle bleeding
___Clots
___Menopause: Age: _____years
___Hysterectomy?
___Vaginal discharge
___Post-coital bleeding
___Vaginal sores
___Last pap
___Breast lumps
___Nipple discharge
___Breast tenderness
___Fibroids
___Ovarian cysts
___Abnormal pap smear
___Endometriosis
___Painful intercourse
___PMS
___Moodiness
___Painful intercourse
___Change of libido

ACKNOWLEDGEMENT OF RECEIPT OF HEALING EDGE NOTICE OF PRIVACY PRACTICES

I understand that under the HIPAA (Health Insurance Portability Account and Ability Act of 1996) that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple HEALING EDGE practitioners who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers, if applicable.
- Conduct normal clinic activities and operations such as quality assessments, employee review activities, training of medical students that see patients at our office, licensing and conducting or arranging for other business activities.

By signing below, I understand Healing Edge Privacy Practices and acknowledge the receipt of the notice.

____   ____________________
Patient Signature   Date

____ ______________________

Witness Signature Date

CANCELLATION POLICY

All appointments require a 3-hour advance notice. Please arrive ten minutes prior to your scheduled time. All appointments begin and end at the scheduled times.

Lateness: If a session starts late due to client's late arrival, the time left will be used to its best advantage and will still end at the appointed time. The session will still be charged full price.

Cancellation: If you cannot make your scheduled appointment, please offer a minimum of 3 hours advanced notice to cancel or reschedule. Clients that cancel within 2-hours of the scheduled time will be charged $25. Clients that do not show up will be charged the full cost of the scheduled session.

Cancellation of Packages: Any partially used portion of the package will be package will be charged at the full rate of treatments.

Sickness: We recognize that both therapists and clients are vulnerable to infections and therefore ask clients to cancel appointments when they are feeling unwell. If a client presents with signs and/or symptoms of illness that contraindicated, treatment will be re-scheduled to protect the health of both the client and the therapist.

Acknowledgement by Initials of patient _______________