Restoration Health & Chiropractic

PLEASE FILL OUT CAREFULLY!!

Oriental Medicine often uses unusual or seemingly insignificant body changes to diagnose the cause of health problems. Some of the following questions **may not appear** to be related to your primary health problem, but your best answer to each question will provide us with the information we need to make a precise diagnosis.

~Restore Function~

HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

I. General Patient Information

Date: ____/____/____ Name: ____

____

Address: ____

City, State, Postal Code: ____
Home Phone: _(______)_________________________ Cell Phone: _(______)___________________________
Work Phone:_(_____)___________________________

Email Address: ____
Age: ______ Date of Birth: ____/____/____ Place of Birth: ______________________________________

Gender: ☐M ☐F ☐Married ☐Single Height: ____'____" Weight: ______lbs.

Occupation:_______________________________Employer:____
Hours worked per week ______ Is your health complaint related to work? ☐ Yes ☐ No ☐Maybe

How did you hear about our office? ____

Guardian (if under 18): ____

Person to notify in an emergency____________________________________ Relationship ________________

Daytime phone for above person _(______)__________________________

Major Complaint(s), in order of significance to you:

1. ____ 4. ____
2. ____ 5. ____
3. ____ Additional:________________________________

How do these conditions impair your daily activities?___________________________________ ___________

____

II. Patient Medical History

How was your childhood health?____

Hospital Visits/Stays:____

Recent tests: (please indicate test results and date below)

□Physical	□Cholesterol	□Prostate	□Blood (which?)
□HIV/STD	□Pap smear	□Mammography	□Other:____________________

Test Results and Date:____

Check any you have had in the past:

□Diabetes	□Allergies	□Glaucoma	□Rheumatic Fever
□Heart Disease	□CVA (stroke)	□Vein condition	□Thyroid disorder
□Asthma	□Pneumonia	□Tuberculosis	□Emphysema
□Jaundice	□Gonorrhea	□Mumps	□Bleeding tendency
□Syphilis	□Measles	□Chicken pox	□Nervous disorder
□Meningitis	□HIV	□Polio	□Mononucleosis
□Epilepsy	□High fever	□Hepatitis	□Multiple Sclerosis
□Paralysis	□Cancer	□Migraines	□High blood pressure
□Other lung illnesses	□Other liver illnesses	□Other heart illnesses	□Other kidney illnesses
□Vasectomy	□Sleep Apnea	□Shingles	□Anemia

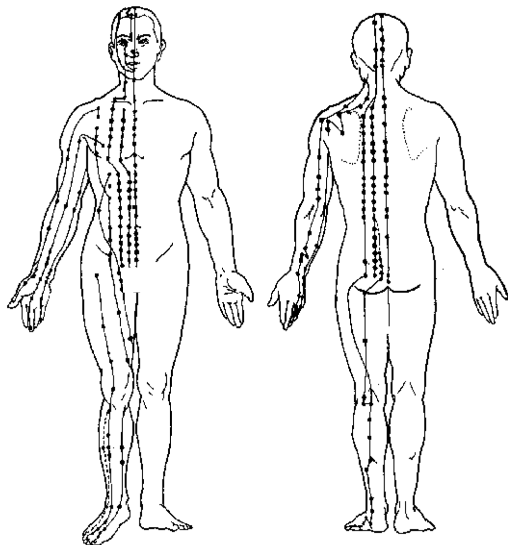
□Other:__________________________________

Immunizations:____

Surgeries:____

Serious injuries or accidents:____

III. **Patient Profile**



Please clearly mark any areas of pain (with xxxxx's), scars (with ------) and numbness (with OOOO's).

Is the pain:

□Sharp □Burning □Aching
□Cramping □Dull □Moving
□Fixed Other:________________

Do the following lessen the pain?

□Pressure □Cold □Heat
□Exercise □Other:______________________

Do the following worsen the pain?

□Pressure □Cold □Heat
□Other:___________________________

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function).

Overall Energy, Dampness

□Low energy
□General weakness
□Easily catch colds
□Difficulty keeping eyes open in the daytime
□Feel worse after exercise
□Overall achy feeling in the body
□Low libido □Excessive libido

□General sensation of heaviness in the body
□Mental heaviness
□Mental fogginess
□Dizziness
□Swollen joints (where? ______________________)
□Edema (where?______________________)
□Skin is often damp or moist

Overall Temperature (Kidney function)

- Cold body temperature (more sensitive to cold than the average person)
- Cold sensation in the knees
- Can get chilled to the bone (hard to get warm again)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day or night

- Hot body temperature (sensation)
- Alternating fevers and chills
- Take water to bed ☐Excessive Thirst
- Easily Perspire ☐Excessive Perspiration
- Rarely Perspire…☐even when exercising
- Graying Hair

Eyes, Ears, Nose, Throat

- Headaches ☐Migraines
- Seasonal Allergies ☐Continuous Allergies (dust, etc)
- Sinus congestion ☐Nasal discharge ☐Sneezing

Dry: ☐lips ☐mouth ☐nose ☐throat

Eyes: ☐Itchy ☐Bloodshot ☐Dry ☐Watery ☐Gritty

- See floating black spots ☐Decreased night vision

- High pitched ringing in ears
- Low pitched ringing in ears
- Ear aches
- Mouth sores ☐Tongue sores ☐Bad breath
- Bleeding, swollen, painful gums
- Sore throat ☐Phlegm in throat
- Difficulty Swallowing
- Jaw Pain (TMJ)

Heart & Circulation function:

- Mental confusion
- Chest pain
- Chest pain traveling to shoulder
- Drink coffee # of cups per week: ________
- Difficulty falling asleep
- Difficulty keeping asleep
- Nightmares
- Wake unrefreshed

- Anxiety
- Restlessness
- Palpitations
- Chest tightness
- Sores on the tip of the tongue
- Pain radiating down the arm
- Varicose Veins, where?________________
- Spider Veins, where?________________

Lung function:

- Difficulty breathing
- Shortness of breath
- Cough
- Chest congestion
- Asthma: ☐ongoing ☐in the past

- Smoke cigarettes (# of cigarettes per day: _______)
- Chew tobacco
- Sadness
- Melancholy
- Dry Skin ☐Cracks in hands or feet
- Sleep Apnea

Digestive Power / Stomach function:

- Low appetite ☐Excessive appetite
- Abrupt weight gain ☐Abrupt weight loss
- Fatigue after eating ☐Easily bruised
- Hemorrhoids
- Over-thinking
- Worry
- Nose Bleeds

- Acid reflux ☐Heart burn ☐Mouth sores
- Bad breath ☐Stomach Pain ☐ Nausea
- Vomiting ☐Abdominal bloating ☐Belching
- Passing gas ☐Hiccoughs ☐Gurgling noise in the stomach ☐Ulcer (diagnosed)
- Burning sensation after eating
- Feel better after eating
- Feel better before eating

- Other bleeding issues (describe)_______________________________________
- Prolapsed organs (previously diagnosed, which organs? ________________________________

Large Intestine, Small Intestine function:

- Loose stools ☐Constipated
- Diarrhea ☐Incomplete BM (Bowel Movement)
- Alternating diarrhea and constipation
- Feel worse before BM ☐Feel better before BM

- Blood in stools
- Mucous in stools
- Undigested food in stools
- Frequent BM # per day_____

Liver, Gall Bladder function:

☐Anger easily ☐Frustration
☐Depression ☐Irritability
☐Pain in the ribs
☐Tightness in the chest
☐Bitter taste in the mouth
☐Tingling sensation ☐Numbness
☐Weak fingernails
Muscle: ☐spasms ☐twitching ☐cramping
☐Recreational drugs (Which? ____________________)

☐Gall stones (☐history or ☐current)
☐Gallbladder removed
☐Seizures ☐Convulsions
☐Skin rashes, where?___________________
☐Drink alcohol
☐Headache at the side(s) of the head
☐PMS symptoms (more detail below)
☐Restless Leg Syndrome
☐Exposure to toxicity
☐Cold Hands ☐ Cold Feet

Kidney, Urinary Bladder function:

☐Frequent cavities, other dental problems (past or present)
☐Easily broken bones
☐Weakness in low back
☐Memory problems
☐Excessive hair loss

☐Kidney stones
☐Wake during the night twice or more to urinate
☐Lack of bladder control
☐Fear
☐Easily startled

Urination:

☐Dark yellow (often)
☐Reddish ☐Blood in Urine
☐Cloudy
☐Scanty
☐Profuse
☐Interrupted
☐Weak Stream
☐Sexually transmitted disease (Which? ____________________

☐Burning
☐Painful
☐Difficult
☐Urgent
☐Frequent
☐Strong odor
☐Discharge
☐Bladder infections

Muscle/Skeletal

☐Neck tension ☐Pain
☐Limited Range-of-Motion in neck
☐Shoulder tension ☐Pain
☐Limited Range-of-Motion in shoulder
☐Upper back tension ☐Pain

☐Painful knees
☐Weak knees
☐Low back pain
☐Hip pain
☐Pain radiating down leg
☐Pain in Hands ☐ Pain in Feet

☐Muscle weakness, where____
☐Loss of muscle function or paralysis, where____

Women only:

☐Irregular menstrual cycle……………………….For ______☐# of years, ____ ☐ # of months
☐Regular menstrual cycle? Pregnant? ☐Yes ☐No
Number of children:_____ Number of pregnancies:_____
Age of first menstruation:_____ Age of menopause (if applicable):_____
Average number of days of flow:_____ Average number of days of entire cycle: ____to ____

☐Severe Menstrual cramps
☐Mild Menstrual cramps

☐Bleeding between periods
☐Unusual vaginal discharges (please describe)_____
____

Do you experience any of the following pre-menstrual syndromes (PMS)?
How many days before period does the PMS usually start? _______days.

☐nausea ☐vomiting ☐water retention ☐breast swelling
☐food cravings ☐headaches ☐migraines ☐breast tenderness
☐depression ☐irritability ☐anxiety ☐other emotions:____________
☐dull pain, where?__________ ☐sharp pain, where?__________

Women please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (bright red, pale, brown, rusty, dark, purple, other)							
Amount of flow (heavy or light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

☐Swollen testes ☐Testicular pain ☐Impotence ☐Premature ejaculation
☐Feeling of coldness or numbness in external genitalia ☐Other___________________
☐Erectile Dysfunction (ED) ☐ Vasectomy ☐Unusual discharges from the penis

Life Style Choices:

☐Drink caffeinated beverages, # per day _____ ☐Drink or use artificial sweeteners

Exercise: ☐mild ☐moderate ☐vigorous # of hours of exercise per week __________
Diet: ☐vegetarian, ☐vegan, Foods that are avoided or excluded___________________________________

Medications Please check the box if you take any of the medications below.

☐Antacids ☐Antibiotics ☐Aspirin ☐Birth Control Pills ☐Blood Thinning Pills

☐Cortisone ☐Cough Medicine ☐Digitalis ☐Hormones ☐Insulin, Diabetic Pills

☐Iron ☐Laxatives ☐Pain Med. ☐Sleeping pills ☐Blood Pressure Med.

☐Tranquilizers ☐Vitamins ☐Water Pills ☐Weight Reduction Pills ☐Thyroid Med.

Please list all other prescriptions, over the counter medications, and supplements which you use. (if you have a written list please give it to the receptionist to be copied)

____

____

____

Other Comments:____

____

Patient Signature:_____________________________________