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Shawna Phillips, CHom

Comprehensive Health History Form

NAME:		GENDER	HT: WT.
DOB:	LOCATION:	OCCUPATION:	
ADDRESS:		PHYSICIAN'S NAME:	
CITY:	ZIP:	PHYSICIAN'S PHONE:	
HOME PHONE		CELL PHONE/WORK PHONE:	
EMAIL ADDRESS:		☐ YES, YOU CAN SEND ME AN OCCASIONAL EMAIL NEWSLETTER	

REFERRED BY:

Reason for today's visit: _____

_____

Illnesses/Injuries

Have you had?

- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Chickenpox
- ❑ Whooping cough
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Polio
- ❑ Mononucleosis
- ❑ Tuberculosis (TB)
- ❑ Venereal disease (VD)
- ❑ Frequent colds or infection
- ❑ Any broken bones
- ❑ Head injury
- ❑ Poisoning of any kind
- ❑ Skin disorders
- ❑ Recurring headaches
- ❑ Glaucoma
- ❑ Asthma
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Peptic ulcer
- ❑ Liver/gallbladder disease
- ❑ Hemorrhoids
- ❑ Kidney problems
- ❑ Arthritis
- ❑ Recurring backache
- ❑ Nervous breakdown
- ❑ Diabetes
- ❑ Thyroid problems

List any other illness or injuries:

_____
_____
_____
_____
_____
_____
_____

Immunizations

Have you had any of the following immunizations?

- ❑ Polio
- ❑ Diphtheria/pertussis/tetanus (DPT)
- ❑ Measles
- ❑ Mumps
- ❑ Smallpox
- ❑ Tetanus booster (last ten years)

List any others:

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

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Surgery/Hospitalizations

Have you had any of the following removed? When?

❑ Tonsils_____
❑ Appendix _____
❑ Gallbladder_____
❑ Uterus (hysterectomy)_____
❑ One or both ovaries_____

List any operations or periods of Hospitalization for any illness

_____
_____
_____
_____

Allergies

Are you allergic to any: ❑ Foods ❑ Drugs or medication ❑ Other substances

List:_____

Medications

Do you regularly take:

❑ Digestive enzymes
❑ Laxatives
❑ Antacids
❑ Aspirin and cold medicines
❑ Sedatives
❑ Diet pills
❑ Cortisone
❑ Estrogen
❑ Sleeping pills
❑ Thyroid (grains per day____)

List any other medications you are currently taking:_____

Diet/Nutrition

Do you:

❑ Feel your diet is adequate
❑ Ear at irregular intervals
❑ Eat in a hurried atmosphere
❑ Eat quickly and forget to chew
❑ Eat between meals
❑ Drink with meals
❑ Eat out often (more than once a week)
❑ Follow a special or restricted diet
❑ Regularly drink "softened" water
❑ Regularly salt your food
❑ Regularly eat fried foods
❑ Use sugar on your food or in drinks
❑ Use sugar in cooking
❑ Eat foods with artificial coloring
❑ Or flavoring, preservatives
❑ Avoid certain foods supplements

Please list any vitamin, mineral or other dietary supplements you are taking: _____

_____

_____

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Habits/Environment

Do you:

- ❑ Drink alcohol (how much?_____)
- ❑ Awaken feeling unrested
- ❑ Have trouble sleeping
- ❑ Have problems with constipation
- ❑ Exercise: (how much – how often?)
- ❑ Have problems at work, home
- ❑ Have trouble relaxing or enjoying your spare time
- ❑ Drink coffee (cups per day_____)
- ❑ Smoke tobacco (packs per day_____)

Have you been treated for:

- ❑ Alcoholism
- ❑ Drug abuse
- ❑ Eating disorder

What was your mother's pregnancy with you like?

Family History

Which member of your family or near relative had:

- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart problems
- ❑ Kidney problems
- ❑ Cancer
- ❑ High blood pressure
- ❑ Stroke
- ❑ Epilepsy
- ❑ Nervous breakdown
- ❑ Asthma
- ❑ Hives or hay fever
- ❑ Arthritis or gout
- ❑ Thyroid problems
- ❑ Bleeding problems
- ❑ Weight problems

Women Only: Menstrual History/Pregnancies

Do you have:

- ❑ Irregular periods
- ❑ Cramps or pain with period
- ❑ Tension or depression before period
- ❑ Breast tenderness before period
- ❑ Hot flashes at any time
- ❑ Pain during intercourse
- ❑ Any unusual bleeding or discharge

Are you:

- ❑ Pregnant or possibly pregnant?
- ❑ Having problems getting pregnant?
- ❑ Using any method of birth control?

What kind: _____

Age onset of menses: _____

Age at menopause _____

Usual length of cycle: _____days

Usual duration of flow: _____days

Is your flow: *Light* *Medium* *Heavy*

Date last period began: _____

Date of last PAP: _____

Number of :

*# children born alive*_____

caesarian sections_____

premature births_____

stillborn_____

miscarriages_____

abortions_____

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Other physical/mental/emotional illnesses not mentioned above:

Please indicate major events in your life on the timeline. Label with age and year of occurrence.

Birth Now

Musculo-skeletal Problems

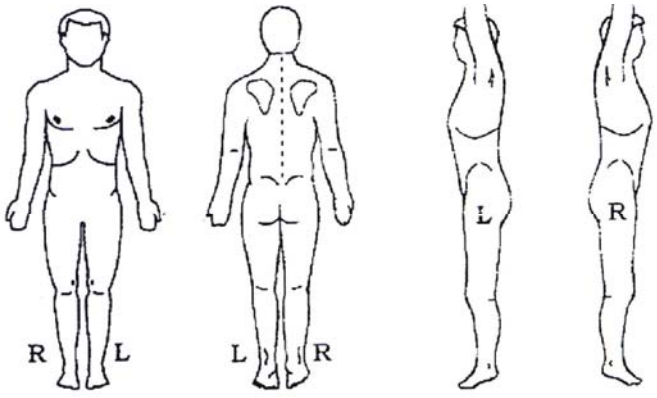
Please indicate if you have had or now have any of the following. ***Please mark on the diagram where you currently have pain or tightness:***

❒Ankle problem
❒Back pain - (location):
❒_____
❒Bed wetting (children)
❒Bone spurs
❒Bronchitis
❒Bunion
❒Bursitis
❒Buttock pain
❒Carpal tunnel syndrome
❒Chest pain
❒Colic (baby)
❒Diaphragm pain or tightness
❒Dizziness
❒Ear or eye problem
❒Edema, general
❒Elbow pain, tennis or golf
❒Fatigue, chronic
❒Fibromyalgia or polymyalgia
❒Fibroids: where?
_____

❒Fracture
_____
❒Fallen on tailbone / coccyx
❒Gall bladder problem
❒Heating pad/ice pack usage
❒Heating /cooling salve usage
❒Hammer toes
❒Hamstring pain or tightness
❒Headaches
❒Heart problem
❒Hernia
❒Hip pain
❒Hip replacement
❒Incontinence/bladder (adult)
❒Infertility
❒ Jaw/TMJ problem
❒ Joint replacement

❒ Knee problem
❒ Lung problem
❒ Migraines
❒ Numbness - (location):
_____

❒ Prostate problem
❒ Rib pain/subluxation
❒ Sacral pain
❒ Sciatica
❒ Scoliosis



❒ Orthodontia, extensive
❒ Orthotics in shoes
❒ Osteoporosis
❒ Pelvic pain
❒ Plantar fasciitis or neuroma
❒ PMS or menopause

❒ Shin splints
❒ Shoulder problem
❒Sinus problem
❒Sleep/energy problem
❒Tinnitus
❒Wrist or thumb pain
❒Other: