Amherst Wellness Center

Health History Questionnaire

Name _____ Age _____ Gender _____
Address _____
_____
_____
Phone _____ Email _____
Height _____ Weight _____ Birthdate _____
Occupation _____ Marital Status _____

Emergency Contact
Name _____
Relationship to you _____
Contact Number _____

----- Main Concern ----------

What would you like help with? _____
_____
How long ago did this problem begin? _____
This problem is: ☐ Constant ☐ Intermittent ☐ Random
What makes the problem worse? _____
What makes the problem better? _____
What do you believe is the cause of your concern? _____
_____
Have you been given a diagnosis for this? If so, when and by whom? _____
_____
What other kinds of treatment have you tried? _____
_____
How does your main concern make you feel? _____
_____
If your behaviors are damaging your own health, would you want to discuss it?
☐ Yes ☐ No
Do you have any secondary concerns? If so, please explain: _____
_____

----- Health History ----------

Please check the boxes for any condition that runs in your family:

☐ Asthma	☐ Allergies	☐ Diabetes
☐ Cancer	☐ Migraines	☐ Heart Disease
☐ High blood pressure	☐ Seizures	☐ Hepatitis
☐ Stroke	☐ Thyroid Disease	

Please list past significant physical traumas (eg auto accidents) and all hospitalizations or surgeries: _____
_____

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Please list all medications/supplements you are currently taking : _____
_____
_____
On average, how many times a year are you sick? _____
When you are sick, how long does it last? _____

For the sections below, please check the box if you have any of the following:

----- Skin -----

Do you run hot or cold easily? → ☐ Hot ☐ Cold
☐ Dry skin ☐ Red skin ☐ Bruising easily
☐ Sweating easily ☐ Night sweats (not related to menopause)

----- Head, Eye, Ear, Nose, Throat -----

☐ Headache → If yes, what area of the head? _____
☐ Dizziness → If yes, any particular time? _____
☐ Dry hair ☐ Oily hair ☐ Thin hair
☐ Dry/red eyes ☐ Floaters / cataracts ☐ Sinus congestion
☐ Tinnitus/ringing in the ears → If yes: ☐ High pitch ☐ Low pitch
☐ Dry throat ☐ Sore throat ☐ Lump in throat
☐ Coughing up phlegm → If yes, what color? _____
☐ Bleeding gums ☐ Tongue/canker sores ☐ Dry mouth

----- Lung -----

☐ Shortness of breath → If yes: ☐ On inhalation ☐ On exhalation
☐ Chest constriction/tightness ☐ Asthma ☐ Cough
☐ Environmental Allergies → If yes, to what? _____

----- Heart -----

☐ Palpitations ☐ Murmuring ☐ Cold hands or feet
☐ Varicose veins ☐ High blood pressure ☐ Low blood pressure

----- Gastrointestinal -----

My appetite is: ☐ Low ☐ Normal ☐ High

What are your food & drink choices these days? (include coffee & alcohol)

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

☐ Bloating/indigestion ☐ GERD/Heartburn ☐ Gallstones
☐ Nausea/Vomiting ☐ Always thirsty ☐ Gas
☐ Food Cravings → If yes, to what? _____
☐ Food Allergies/Sensitivities → If yes, to what? _____

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----- Bowel Movements ----------

How many bowel movements do you have a day? _____

Consistency of stool:

☐ Watery ☐ Loose ☐ Formed ☐ Hard

Color of stool (ie. which shade of brown): _____

☐ Bloody stool ☐ Undigested food in stool ☐ Urgent movements

☐ Straining to go ☐ Incomplete movements ☐ Incontinent

----- Urinary Tract ----------

Amount of urine is:

☐ Below fluid intake ☐ Equals fluid intake ☐ More than fluid intake

Color of urine (ie. which shade of yellow): _____

☐ Cloudy urine ☐ Bloody urine ☐ Straining to go

☐ Intermittent flow ☐ Incontinent ☐ Urgent flow

☐ Kidney Stones ☐ Nocturia/waking to urinate

----- Sexual Function ----------

For men:

☐ Erectile dysfunction ☐ Premature ejaculation ☐ Nocturnal emissions

☐ Priaprism/sustained erections ☐ Penile sores ☐ Enlarged prostate

For women:

pregnancies: _____ # births: _____

Are you pregnant or possibly pregnant now? → ☐ Yes ☐ No

Are you on birth control now? → ☐ Yes ☐ No

If yes, which kind and for how long? _____

Age at first period: _____ # days of bleeding: _____

days from first day of bleeding to first day of next period: _____

Last menstrual period: _____

Color of period (ie. which shade of red): _____

☐ Light flow ☐ Average flow ☐ Heavy flow

☐ Clotting → If yes, size & color? _____

☐ Vaginal discharge → If yes, color & smell? _____

☐ Painful periods ☐ Vaginal dryness ☐ Vaginal sores

Premenstrual symptoms:

☐ Cramps ☐ Fatigue ☐ Irritability

☐ Bloating ☐ Food cravings ☐ Weepy

Menopausal symptoms:

☐ Hot flashes ☐ Night sweats ☐ Back/abdominal pain

☐ Other (please specify): _____

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----- Sleep ----------

hours sleep: _____

☐ Problems falling asleep ☐ Problems staying asleep ☐ Vivid dreams

Do you wake rested? → ☐ Yes ☐ No

----- Energy ----------

My energy level is: ☐ Low ☐ Medium ☐ High

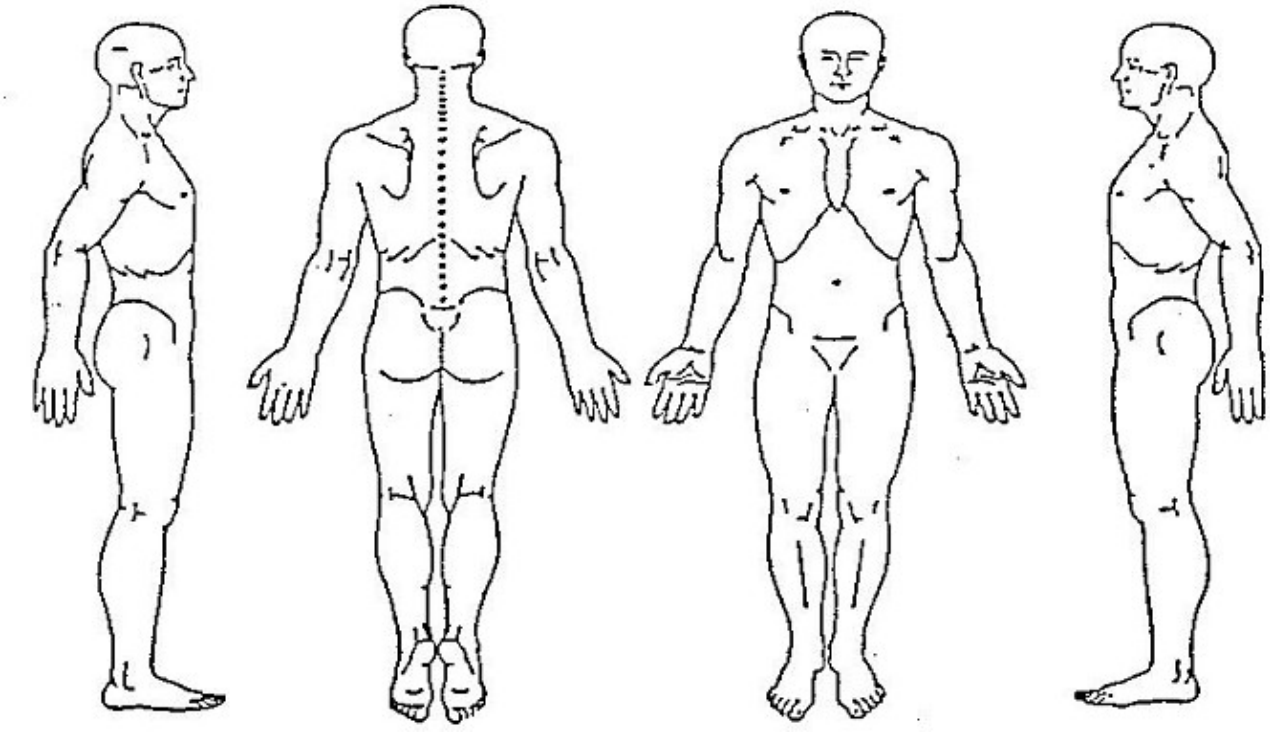
☐ Energy drops during day → If yes, when? _____

----- Musculoskeletal ----------

What kinds of exercise do you do? _____

How frequently do you exercise? _____

Please circle any areas of pain or tension:



----- Mental/Emotional ----------

☐ Seizures ☐ Difficulty concentrating ☐ ADD/ADHD

Tendency to any emotion:

☐ Anxiety ☐ Depression ☐ Worry ☐ Anger

☐ Frustration ☐ Panic ☐ Grief ☐ Sadness

Have you considered or attempted suicide? → ☐ Yes ☐ No

Do you use any drugs/chemicals recreationally? → ☐ Yes ☐ No

Do you trust people? → ☐ Yes ☐ No

Do you have a faith or spiritual practice? → ☐ Yes ☐ No

What do you to do relax? _____