Client Name:_____

Comprehensive Health History

Please answer the following questions. Your responses will help us assess your current needs and coordinate your services. Thank you.

Date of last physical exam,_____ **Height**_____ **Weight**_____

Primary Care Physician (Family Doctor) _____

Does pain interfere with your daily activities? ☐ **YES** ☐ **NO**

Are your immunizations up to date? ☐ **YES** ☐ **NO**

Please check any of the following problems you currently have or have had in the past.

☐ AIDS/HIV	☐ Epilepsy/Seizures	☐ Menstrual Pain
☐ Anemia	☐ Eye Disease/Blindness	☐ Neuropathy
☐ Anxiety	☐ Fibromyalgia/Muscle Pain	☐ Oral Health/Dental Problems
☐ Arthritis	☐ Glaucoma	☐ Schizophrenia
☐ Asthma	☐ Headaches/Migraines	☐ Sexual Problems
☐ Bipolar Disorder	☐ Head Injury/Brain Tumor	☐ Sexually Transmitted Disease
☐ Bleeding Disorder	☐ Hearing Problems/Deafness	☐ Sleep Disorder
☐ Blood Pressure (high or low)	☐ Heart Disease	☐ Speech Problems
☐ Blood Transfusion	☐ Hepatitis/Jaundice	☐ Stomach/Bowel Problems
☐ Bone/Joint Problems	☐ High Cholesterol	☐ Stroke
☐ Cancer	☐ Hyperactivity/ADHD	☐ Suicide Attempts/Thoughts
☐ Depression	☐ Kidney Disease	☐ Thyroid Problems
☐ Diabetes	☐ Learning Problems	☐ Tuberculosis
☐ Eating Disorder	☐ Lung Disease	☐ Other_____

Please list any family members who have or had any of the above conditions.

Family Member **Condition**

_____

_____

_____

_____

_____

_____

Please list any hospitalizations or surgical procedures within the last three years. **NONE _____**

Hospital **City** **Date** **Reason**

_____

_____

_____

_____

_____

_____

Please list any allergies or sensitivities to foods or medications. **NONE_____**

_____

_____

_____

_____

_____

_____

Pregnancy History **NOT APPLICABLE_____**

Are you currently pregnant?	☐ **YES**	☐ **NO**
If yes, are you receiving prenatal healthcare?	☐ **YES**	☐ **NO**
Are you currently breastfeeding?	☐ **YES**	☐ **NO**
Are you having any complications related to your pregnancy?	☐ **YES**	☐ **NO**

Have you had any of the following symptoms within the last 60 days?

☐ Ankle Swelling	☐ Falling	☐ Panic Attacks
☐ Bed Wetting	☐ Hair Changes/Loss	☐ Penile Discharge
☐ Blood in Stool	☐ Hearing Loss	☐ Seizures
☐ Breathing Difficulty	☐ Irregular Pulse	☐ Shakiness
☐ Chest Pain	☐ Lightheadedness	☐ Sleep Problems
☐ Confusion	☐ Memory Loss	☐ Tingling in Arms/Legs
☐ Consciousness Loss	☐ Mole/Wart Changes	☐ Tremors
☐ Constipation	☐ Muscle Weakness	☐ Unsteady Gait
☐ Coughing	☐ Nervousness	☐ Urination Difficulty/Pain
☐ Cramps	☐ Night Sweats	☐ Vaginal Discharge
☐ Diarrhea	☐ Nosebleeds	☐ Vision Changes
☐ Dizziness	☐ Numbness	☐ Vomiting

Please include any other important health information here.