Confidential Health History Intake Form

Please type or write or print clearly.

Client Information

Date: ____________________

Name: ____
Last First MI

Phone: ______________________________

Email: ______________________________

Address: ____
Street Apt. / Unit

____
City ST Zip

Work Information

Occupation: ____________________ Hours per week: ____________________

Relationship: ____________________ Children? ____________________

Health Information

Please list your main health concerns.

Confidential Health History Intake Form

Please type or write or print clearly.

When is the last time you felt really vibrant and well?

Other current major health concerns?

If you could wave a magic wand and change two things about your health right now, what exactly would they be?

Any serious illness, hospitalization, injuries, surgeries, etc., either now or in the past?

Confidential Health History Intake Form

Please type or write or print clearly.

How is the health of your mother?

If deceased, please list any illnesses or medical conditions.

How is the health of your father?

If deceased, please list any illnesses or medical conditions.

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Please type or write or print clearly.

Do you sleep well? ______________________

How many hours? ______________________

Wake up at night? ______________________

Any ongoing sources of inflammation (e.g. eczema or other skin imitation, chronic post-nasal drip, congestion, headaches, achy muscles, joints, swelling, pain, stiffness)?

This section for women only.

Are your periods regular? Yes ☐ No ☐

How many days is your flow? ______________________

How frequent? ______________________

Birth control history: ______________________

Vaginal infections, reproductive concerns? ______________________

Painful or symptomatic? ______________________

Please explain.

Disclaimer and signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: ______________________ Date: ______________________

Symptom Questionnaire

Use this scale to rage the frequency and severity of symptoms you have experienced **over the past two weeks.** If multiple choices are given, specify what applies in the comment section.

- **1** if you **occasionally** have and the effect is **mild**.
- **2** if you **occasionally** have it and the effect is **severe**.
- **3** if you **frequently** or **consistently** have it and the effect is **mild**.
- 4 if you **frequently** or **consistently** have it and the effect is **severe**.

Category	Symptom	Score	Comments
Head	Headache		
	Faintness		
	Dizziness		
	Insomnia		
Nose	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
Mouth	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Tooth ache or gum pain or new dental work		
	Canker sores		
Skin	Acne		
	Hive or another allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb. Which?		
Heart	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		
Lungs	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
Digestion	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or stomach pain. Where?		
	Other pain in GI tract? Where?		

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- 4 if you **frequently** or **consistently** have it and the effect is **severe.**

Category	Symptom	Score	Comments
Joints and Muscles	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		
Weight	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight		
Energy	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness		
Mind	Poor memory		
	Confusion, poor comprehension		
	Poor concentration or focus		
	Difficulty in making decisions		
	Stuttering or stammering		
	Learning disabilities		
Mood	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression		
	Other mood challenges		
Other	Frequent illness		
	Frequent or urgent urination		
	Inability to urinate or low flow		
	Low libido or other sexual dysfunction		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine/Ovarian fibroids		
	Other		
	Tally your scores for this update here:		Total Symptom Score

Any further comments you wish to share?