Health Survey

Today's Date:_____

Name:_____**Age**:_____**M/F**_____**Date of birth**:_____

Address _____

City _____ **State** _____ **Zip** _____

Phone # ( ) _____-_____ **Occupation** _____

Marital Status (circle): Married Divorced Widowed Single **Weight**:_____ **Children**:#_____

CHIEF COMPLAINTS (list in order of importance) the present health concerns, symptoms, and/or problems you are experiencing: _____, _____,

_____, _____, _____,

_____, _____, _____.

Have you had a physical exam in the last 12-24 months? **Yes** or **No**

MEDICATION: Provide name of prescription and over the counter items

Currently Taking:	**Have Taken Previously:**

VITAMINS, HOMEOPATHIC, OR HERBAL SUPPLEMENTS (Include all that you are currently taking and the dosage): _____

MEDICAL HISTORY: Circle **Y** for yes **N** for no if you or your parents have/had any of the following. Indicate a **P** next to conditions that your parents have had.

Measles	Y	N	Scarlet fever	Y	N	High Cholesterol	Y	N
Mumps	Y	N	Diphtheria	Y	N	Kidney Disease	Y	N
Chickenpox	Y	N	Smallpox	Y	N	Hives or Eczema	Y	N
Whooping Cough	Y	N	Heart Disease	Y	N	Obesity	Y	N
Allergies	Y	N	Hernia	Y	N	Osteoporosis	Y	N
Autoimmune Disorders	Y	N	High Blood Pressure	Y	N	Rheumatic fever	Y	N
Diabetes	Y	N	Mono	Y	N	Parkinson's Disease	Y	N
AIDS/HIV+	Y	N	Stroke	Y	N	Thyroid Disease	Y	N
Anemia	Y	N	Tuberculosis	Y	N	IBD (Irritable bowl)	Y	N
Glaucoma	Y	N	Alcohol/Drug Problem	Y	N	Cancer (If yes, what kind)	Y	N
Bleeding tendency	Y	N	Epilepsy	Y	N			
Other:								

SYMPTOMS: Check which one's apply to you:

- ☐ Headaches
- ☐ Dizziness
- ☐ Blurry vision
- ☐ Fainting/blackouts
- ☐ Eye pain/red eye
- ☐ Cataracts/glaucoma
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Difficulty hearing
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Hoarse voice
- ☐ Grinding teeth
- ☐ Neck lumps/swelling
- ☐ Dental issues
- ☐ Sore throat
- ☐ Sore/bleeding gums
- ☐ Difficulty swallowing
- ☐ Cold/canker sores
- ☐ Wheezing
- ☐ Cough up blood
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Swollen ankles
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Chest colds
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Indigestion
- ☐ Nausea
- ☐ Blood in vomit
- ☐ Yellow skin/jaundice
- ☐ constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Gas/bloating
- ☐ Clay colored stool
- ☐ Loss of appetite
- ☐ Excessive appetite
- ☐ Blood in stool
- ☐ Light colored stool
- ☐ Rectal pain/itching
- ☐ Frequent urination
- ☐ Urge to urinate
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Pain with urination
- ☐ Bladder infections
- ☐ Genital sores
- ☐ STDs
- ☐ Genital discharge
- ☐ Aching muscles
- ☐ Numbness/tingling
- ☐ Restless legs
- ☐ Broken bones
- ☐ Weakness
- ☐ Swollen joints
- ☐ Sore joints
- ☐ Leg cramps
- ☐ Tender point
- ☐ Acne
- ☐ Itchy skin
- ☐ Rashes
- ☐ lesions
- ☐ Easy bruising
- ☐ Hives
- ☐ Always cold
- ☐ Always hot
- ☐ Chronic fatigue
- ☐ Weakness
- ☐ Increased hunger
- ☐ Increased thirst
- ☐ Anxiety
- ☐ Loss of sensation
- ☐ Tremor
- ☐ Foggy thinking
- ☐ Lack of strength
- ☐ Convulsions
- ☐ Loss of memory
- ☐ Lack of concentration
- ☐ Paralysis
- ☐ Fluid retention
- ☐ Anemia
- ☐ Swollen glands
- ☐ Painful lymph nodes
- ☐ Wounds heal slowly
- ☐ Depressed
- ☐ Suicidal thoughts
- ☐ Anger easily
- ☐ Afraid of being alone
- ☐ Shy/timid
- ☐ Restlessness
- ☐ Excessive worry
- ☐ Loneliness
- ☐ Critical of others
- ☐ Frequent crying
- ☐ Mental confusion
- ☐ mood swings

Male Reproduction

- ☐ Prostate problems
- ☐ Painful erections
- ☐ Painful urination
- ☐ Infertility
- ☐ Discharge
- ☐ Difficulty/premature ejaculation
- ☐ Swelling in testicles
- ☐ Pain in testicles
- ☐ Trouble maintaining erection

Female Reproduction

- ☐ Lumps in breasts
- ☐ Breast pain
- ☐ Birth control
- ☐ Missed periods
- ☐ Lack of sexual desire
- ☐ Pelvic pain
- ☐ Vaginal discharge
- ☐ heavy periods
- ☐ DNC/Miscarriage
- ☐ Genital eruptions
- ☐ Pain with intercourse
- ☐ Vaginal burning
- ☐ vaginal itching
- ☐ Spotting between periods
- ☐ Difficulty having orgasms
- ☐ Other:

ACTIVITIES:

Occupation:

Hobbies:

Do you exercise regularly? **Yes** or **No** What Type: How long:

How frequent do you exercise?

Do you work in the sun?

HABITS:

Do you smoke?_____ If yes, how often? _____

If an ex-smoker, when did you quit? _____

Do you partake in recreational drugs? _____What substance and how often? _____

Do you drink alcohol? **Y N** If yes, how often?_____Alone or Social gathering (circle)

GEOPATHIC STRESS: How many hours daily do you spend:

Working on a computer?____ Wearing a hearing aid? ____ Talking on cell phone?____
Wearing a wrist watch? ____ Watching TV? ____ Near electrical equipment? ____
Riding in a vehicle? ____ Near copy machines? ____
While sleeping is your head 5-10 feet from an outlet/TV/cell phone? _____

DO YOU DRINK OR CONSUME: (Circle items that apply)

Alcohol	Candy	Carbonated beverages	Cheese
Cigarettes	Coffee	Meals at fast food Restaurants	Fried foods
Luncheon meats	Margarine	Beef	Chicken
Milk or ice cream	Refined Sugar	Saccharine or Aspartame	Chew tobacco
Butter	Bread	Pasta	Cookies

Chocolate	Yogurt	Tea	Nuts

DO YOU CONSUME THE FOLLOWING 1-2 X A WEEK: (Circle items that apply)

Fresh fruit	Kale	Whole grain rice	Beans/Lentils
Turkey	Fresh vegetables	Pre-made meals	Fish

EATING HABITS:

How many times a week do you eat out at restaurants? _____

What type of food do you order? _____

Do you prepare meals at home? _____ If yes, how often? _____

What type of meals do you prepare? _____

Do you (circle): have regular eating schedule skip meals eat meals past 7pm

How much water do you consume: 1 glass a day 2-4 glasses a day 8-8oz. daily

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_____ _____

Signature Date

_____

Print Name