Adult History Form

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Name____ Date____________________________
Address____ Phone__________________________
Age_______ Birthdate____________________ Live With____________________________________

PLEASE FEEL FREE TO ATTACH ADDITIONAL PAGES IF WE HAVE NOT GIVEN YOU ENOUGH SPACE TO WRITE THE INFORMATION REQUESTED. WE DO REVIEW THIS HISTORY TOGETHER SO YOU MAY GIVE INFORMATION THAT IS DIFFICULT TO WRITE.

PRESENT PICTURE

Please attach a 3 day diet history, including all foods that you consume for 3 days

Are you a thirsty person-hot, cold, iced?____

Food cravings____

Food you dislike____

Food reactions____

Sleep patterns(ex. Hours of sleep, restless, refreshing, interrupted and by what, sleep position, Covering used, windows open or closed, dreams/nightmares)__________________________________

____

____

What do you do for exercise?(frequency/type)____

____

Allergies(to what and the type of reactions)____

____

____

Surgeries/Hospitalizations(include year)____

____

Significant illnesses/Injuries(include year)____

____

Signficant Emotional issues/experiences(include year)__________________________________

____

PRESENT PROBLEMS/CONCERNS____

____

____

Describe your present Health and Sense of Well-Being__________________________________

____

____

PERSONAL HISTORY

1. How much do you smoke, drink, use any other drugs?_______________________________________
2. What medications, vitamins, minerals, herbs, or homeopathics do you use? PLEASE BRING THESE WITH YOU WHEN YOU COME FOR YOUR VISIT_______________________________________

____

Please answer all questions in terms of significant past history and present condition. If you have any of these conditions I will need to know when it started, how does it affect your life and what makes it better or worse.

Any problem with:

1. Vision/Eyes____
2. Hearin/Ears____
3. Taste/Mouth/Tongue____
4. Smell____
5. Touch____
6. Walking____
7. Sitting____
8. Getting in/out of bed____
9. Running____
10. Picking up something____
11. Joint weakness____
12. Muscle weakness____
13. Sinus problems/stuffy nose____
14. Runny nose/postnasal drip____
15. Nose Bleeds____
16. Spitting up blood____
17. Shortness of breath____
18. Cough, congestion, sneezing____
19. Dizziness____
20. Swelling of the hands/feet____
21. Chest pain____
22. Pains in arms/hands____
23. Pains in legs/feet____
24. Low back pain____
25. Neck pain____
26. Headaches____
27. Palpitations____
28. Night sweats/hot flashes____
29. Loss of apetite/thirst____
30. Gain of apetite/thirst____
31. Difficulty with chewing/swallowing____
32. Passing gas/belching/heartburn____
33. Constipation/diarrhea____
34. Nausea/vomitting____

35. Change in stool____
36. Change in urine____
37. Itching/burning/pain/leakage with urination____
38. Itching/burning/pain vaginally____
39. Pain with intercourse____
40. Difficulty achieving an erection/orgasm____
41. Loss of sex drive/libido____
42. Discharge/lumps in your breasts____
43. Dry/oily skin____
44. Skin rashes/scaling____
45. Itching____
46. Heat/cold sensitive____
47. Hair loss/loss of sheen/dry____
48. Nails brittle/peeling____
49. Swelling/lumps/bumps____

OTHER HISTORY

Any fears (ex. Heights, small spaces, spiders, thunder)____
____

How do you handle anger? ____

Do you cry? ____________________________When?____

Do you like parties?_____________________ Solitary activity?____________________________________

Do you like consolation?_________________ Performing?____

Favorite weather____

Do you prefer indoors/outdoors?__________________Mountains/ocean?_____________________________

Have you ever been raped or molested?____

Have you ever been diagnosed with a sexually transmitted disease and if so what?_________________________
____

Have you ever been told you have a fibroid, endometriosis, cysts?____________________________________
____

What is your usual height and weight and what is it now?____

What is your blood pressure?____________________Any problems with anemia?______________________

Any problems with your thyroid or any other glands or hormones?___________________________________
____

Any recent blood work/tests you have had particularly in the past 2 years, bring copies______________________
____

WOMEN'S HEALTH

Last menses_____________Number of days between periods_______Mod, light, or heavy____________________

Number of days menses lasts__________Color of blood through cycle_________________________________

Number of pregnancies_________Number of births______Abortions_______Miscarriages___________________

Stillbirths__________Problems getting pregnant____
____

Experience of labor and delivery____

____

Did you nurse or bottle feed/how was this for you?____

____

Cramps/(what days of cycle, intensity, what makes it better/worse)______________________________________

____

Moodiness associated with menses (what days of cycle, intensity, anger or tears, what makes it better/worse)

____

____

Other symptoms associated with menses (what part of the cycle, intensity, what makes better/worse, ex. Headaches, bloating, fluid retention, fatigue, constipation, diarrhea, heaviness in pelvis/legs)______________________________

____

____

Changes in your menses since first menses (give age______) what has changed, give length of time since change and anything that you feel has caused this change____

____

____

Are you aware when you ovulate?____________Symptoms?____

FAMILY HISTORY

Please list all significant medical history for the following individuals (if deceased list age and cause of death. Also, include your emotional relationship with these persons if significant):

Father____

____

Mother____

____

Paternal grandmother____

____

Paternal grandfather____

____

Maternal grandmother____

____

Maternal grandfather____

____

Sisters____

____

Brothers____

____

Spouse/Partner____

____

Children____

____

Other significant people in your life____

Please describe yourself briefly so I can picture you (such as temperament, hobbies, interests, how you like to dress, where you like to go, any nicknames, what you like to do for fun, what you do just for yourself?????)

PLEASE FEEL FREE TO ADD ANY OTHER INFORMATION YOU FEEL MIGHT BE HELPFUL, OR THAT HAS BEEN MISSED