NEW HOPE TECHNOLOGIES, INC.

Restoring Health Naturally

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Health History Questionnaire

Important: Complete this form as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a role in differential diagnosis, treatment and ongoing support.
All information is kept strictly confidential.

GENERAL PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Email: _____

Legal Guardian: (if under 18 years of age) _____

Emergency Contact: (name and phone number) _____

Gender: _____ Height: ____ ' ____ " Weight: ____ lbs.

Occupation: _____ Employer: _____

How did you hear about us? _____

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

How do these conditions impair your daily activities? _____

_____

PATIENT MEDICAL HISTORY

How was your childhood health? _____

Hospital visits/stays: _____

Recent Tests: (please indicate test results and date below)

❑ Physical ❑ Cholesterol ❑ Prostate ❑ Blood (which?) ❑ HIV/STD ❑ Pap Smear ❑ Mammography ❑ Other

Test results and date: _____

Immunizations (not including childhood vaccines). List any **adult** shots for Tdap, Covid-19 mRNA, flu, shingles, Hepatitis B, etc.: _____

Surgeries:_____

Integrative / Alternative Medicine Therapies: _____

Check any that you have had in the past:

❑ Diabetes	❑ Allergies	❑ Glaucoma	❑ Rheumatic Fever	❑ Heart Disease
❑ CVA (stroke)	❑ Vein Condition	❑ Thyroid Disorder	❑ Asthma	❑ Pneumonia
❑ Tuberculosis	❑ Emphysema	❑ Jaundice	❑ Gonorrhea	❑ Mumps
❑ Bleeding Tendency	❑ Syphilis	❑ Measles	❑ Chicken Pox	❑ Nervous Disorder
❑ Meningitis	❑ HIV	❑ Polio	❑ Mononucleosis	❑ Epilepsy
❑ High Fever	❑ Hepatitis	❑ Multiple Sclerosis	❑ Paralysis	❑ Cancer
❑ Migraines	❑ Myocarditis	❑ Infections	❑ High Blood Pressure	❑ Other Heart Illness
❑ Other Lung Illness	❑ Other Liver Illness	❑ Other Kidney Illness	❑ Vaccine Injury	

❑ Other _____

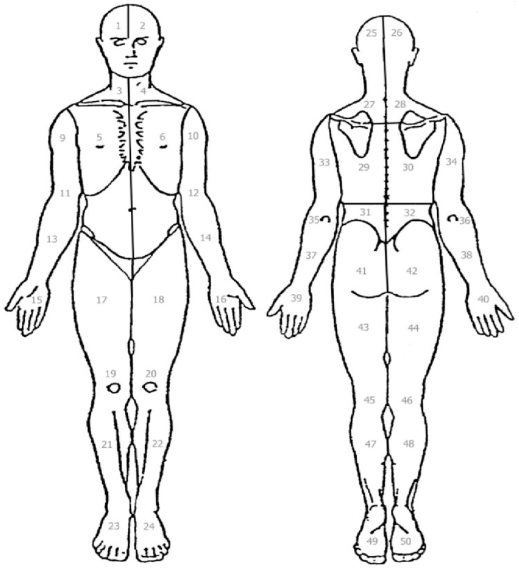
PATIENT PROFILE

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars). Is the pain:

❑ Sharp ❑ Burning ❑ Aching

❑ Cramping ❑ Dull ❑ Moving

❑ Fixed ❑ Other:



Do the following improve the pain?

❑ Pressure ❑ Cold ❑ Heat

❑ Exercise ❑ Other: _____

Do the following worsen the pain?

❑ Pressure ❑ Heat

❑ Cold ❑ Other: _____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it may indicate that you have a problem with that organ's function):

OVERALL TEMPERATURE (Kidney function)

❑ Sweaty feet ❑ Night sweats ❑ Perspire easily ❑ Hot body temperature (sensation)

❑ Lack of perspiration ❑ Afternoon flushes ❑ Thirsty ❑ Cold body temperature (sensation)

❑ Cold hands and feet ❑ Take water to bed ❑ Hot flashes any time ❑ Heat in the hands, feet, and chest

OVERALL ENERGY (Lung, Kidney function)

❑ Shortness of breath ❑ Low energy ❑ Feel worse after exercise ❑ General weakness

❑ Easily catch colds daytime ❑ Difficulty keeping eyes open in the daytime

OVERALL BLOOD (Liver, Spleen, Heart function)

❑ Dizziness ❑ See floating black spots ❑ What is your blood type? _____ (i.e., O+/- A+/-, etc.)

HEART FUNCTION

❑ Palpitations ❑ Anxiety ❑ Mental confusion ❑ Sores on the tip of the tongue

❑ Frequent dreams ❑ Wake unrefreshed ❑ Chest pain traveling to shoulder

LUNG FUNCTION

❑ Nasal Discharge (color: _____) ❑ Coughs ❑ Dry throat ❑ Sneezing

❑ Allergies (to what? _____) ❑ Nose Bleeds ❑ Dry nose ❑ Achy feeling

❑ Headache (location: _____) ❑ Sinus Congestion ❑ Dry skin ❑ Stiff neck

❑ Smoke cigarettes (# of cigarettes a day: ___) ❑ Dry Mouth ❑ Sore throat ❑ Stiff shoulders

❑ Alternating fever and chills ❑ Sadness ❑ Difficulty breathing ❑ Melancholy

SPLEEN FUNCTION

❑ Low appetite ❑ Abdominal gas ❑ Easily bruised ❑ Over-thinking

❑ Worry ❑ Abrupt weight gain ❑ Abrupt weight loss ❑ Abdominal bloating

❑ Fatigue after eating ❑ Hemorrhoids ❑ Pensive ❑ Gurgling noise in the stomach

❑ Prolapsed organs (previously diagnosed, which organ? _____)

SPLEEN, STOMACH, LARGE INTESTINE, SMALL INTESTINE FUNCTION

❑ Loose ❑ Incomplete ❑ Blood in stools ❑ Undigested food in stools

❑ Constipated ❑ Diarrhea ❑ Mucous in stools

DAMPNESS TRAPPED IN THE BODY

❑ Mental heaviness ❑ Mental fogginess ❑ Swollen hands ❑ Chest congestion ❑ Nausea

❑ Mental sluggishness ❑ Swollen feet ❑ Swollen joints ❑ Snoring

❑ General sensation of heaviness in the body

STOMACH FUNCTION

❑ Large appetite ❑ Heartburn ❑ Belching ❑ Burning sensation after eating

❑ Bad breath ❑ Acid regurgitation ❑ Stomach pain ❑ Bleeding, swollen or painful gums

❑ Ulcer (diagnosed) ❑ Hiccups ❑ Vomiting ❑ Mouth (canker) sores

LIVER, GALL BLADDER FUNCTION

❑ Alternating diarrhea and constipation ❑ Frustration ❑ Tingling sensation ❑ Convulsions

❑ Headache at the top of the head ❑ Depression ❑ Numbness ❑ Lump in the throat

❑ Tight sensation in the chest ❑ Irritability ❑ Muscle spasms ❑ Neck tension

❑ Bitter taste in the mouth ❑ Skin rashes ❑ Muscle twitching ❑ Shoulder tension

❑ High-pitched ringing in the ears ❑ Chest pain ❑ Muscle cramping ❑ Drink alcohol

❑ Gall stones (history or current) ❑ Anger easily ❑ Seizures

❑ Limited Range-of-Motion, neck ❑ Vertigo ❑ Pain under the ribcage

❑ Limited Range-of-Motion, shoulder ❑ Tendon. ligament or joint problems

❑ Sexually transmitted disease (which?) _____

❑ Recreational drugs (which?) _____, How much per week? _____

❑ Frequently unable to adapt to stress (What causes the stress?) _____

EYES (Liver function)

❑ Itchy ❑ Dry ❑ Blurry vision ❑ Decreased night vision

❑ Bloodshot ❑ Watery ❑ Near-sighted

❑ Hot ❑ Gritty ❑ Far-sighted

KIDNEY, URINARY BLADDER FUNCTION

❑ Frequent cavities ❑ Low back pain ❑ Bladder infections ❑ Easily startled

❑ Easily broken bones ❑ Memory problems ❑ Fear ❑ Lack of bladder control

❑ Sore knees ❑ Excessive hair loss ❑ Kidney stones ❑ Low-pitched ringing the ears

❑ Weak knees ❑ Cold sensation in the knees ❑ Wake during the night twice to urinate

LIBIDO

❑ Normal ❑ High ❑ Low

URINATION

❑ Normal color ❑ Reddish ❑ Profuse ❑ Painful ❑ Urgent

❑ Dark yellow ❑ Cloudy ❑ Strong color ❑ Discharge ❑ Frequent

❑ Clear ❑ Scanty ❑ Burning ❑ Difficult

WOMEN ONLY

Regular menstrual cycle? ❑ Y ❑ N Number of children: _____ Age of first menstruation: _____

Average number of days of flow: _____ Vaginal discharge? ❑ Y ❑ N Pregnant? ❑ Y ❑ N

Number of pregnancies: _____ Age of menopause (if applicable): _____

Average number of days of entire cycle: _____ Bleeding between periods? ❑ Y ❑ N

Do you experience any of the following pre-menstrual syndromes?

❑ Nausea ❑ Vomiting ❑ Water retention ❑ Breast swelling

❑ Food cravings ❑ Headaches ❑ Migraines ❑ Breast tenderness

❑ Depression ❑ Irritability ❑ Anxiety ❑ Other emotions

❑ Dull pain, (where?): _____ ❑ Sharp pain, (where?): _____

MEN ONLY

❑ Swollen testes ❑ Testicular pain ❑ Impotence ❑ Premature ejaculation

❑ Feeling of coldness or numbness in external genitalia ❑ Other_____

EVERYONE: MEDICATIONS AND DIETARY SUPPLEMENT LOG

Date Started	Medication / Supplement	Reason for Taking	Dosage	Quantity	Frequency

DIETARY INTAKE

Please **briefly** list typical foods eaten for each meal and number of beverages consumed each day for the following:

Diet Type		
Breakfast		
Lunch		
Dinner		
Snacks		
Beverages		
Water		
Soda Pop		
Milk		
Fruit Juice		
Coffee		
Tea		
Alcohol		
Other		
Fasting?		