

Restoring Health Naturally

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 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:

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

PATIENT PROFILE

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

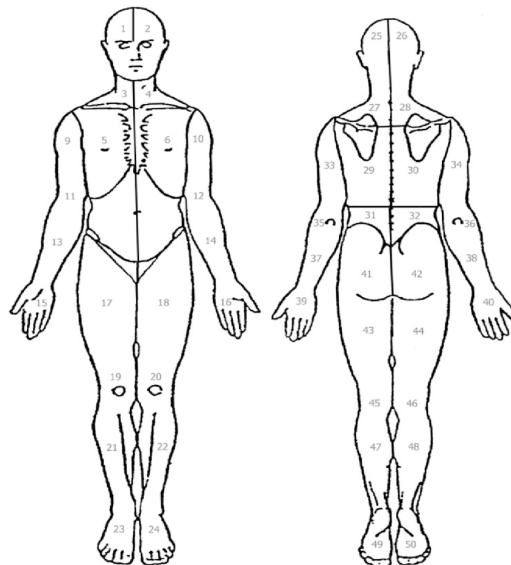
- | | | |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |

Do the following improve the pain?

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Do the following worsen the pain?

- | | |
|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Cold | <input type="checkbox"/> 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)

- | | | | |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Perspire easily | <input type="checkbox"/> 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

