The Healthy Closet
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Client Health History:
Name: ____

Birthdate: ____

Age: ____
Who referred you to us? ________________________________

Primary Care Physician: ________________________________

Other:____

Physicians Involved in Care:

____

____

Health History – Initial Consult

____

Right handed: _______________ Left handed: __________________

For what reason are you seeing us today?

____

____

____

____

When did your symptoms first start?

____

____

Location of symptoms?

____

____

Severity of symptoms. (Scale of 1-10)

____

Worse at any certain time of day?

____

What makes it better?

____

What makes it worse?

____

Does this problem affect your job? __________ Social life? ____________
Family life? ________________________ Exercise? ___________________

Do you have any Allergies :

____

____

Over-the-Counter and prescription Medications currently taking:

____

____

____

PAST MEDICAL HISTORY: (Circle)
Seizures, Stroke, Spine Problems, Anxiety, Depression, Panic Attack, Broken Bones:

When?

____

____

Heart Attack, Stomach Ulcers, Muscle Disease, Diabetes, Arrhythmia, Hepatitis, Kidney Problems, Hypertension, Kidney Stones, Angina, Asthma, Arthritis, Drug Abuse, Prostate Disease, Thyroid Disease, Blood Clots, High Cholesterol, Cancer:
Type?

____

____

SURGICAL HISTORY:

____

____

____

SOCIAL HISTORY:

Single _________________________ Married ______________________

Widowed ______________________ Partner _______________________

With whom do you live?

____

Employment/Occupation:

____

Tobacco use: Yes ___________ No ___________ Never ____________

How many years? _______________________________________

How many packs per day? _________ When did you quit? __________

Alcohol use: Yes ____________ No ____________ Beer? __________

Wine? ______________________ Hard Liquor? ___________________

Servings per day of: Coffee _________________ Tea ______________

FAMILY HISTORY:

____

____

Similar type of illnesses that you have now ________________________

Stroke ____

Alzheimer's Dementia ____

Seizures/Epilepsy ____

Muscle Disease ____

Nerve Disease/Neuropathy ____________________________________

Tremor ____

Brain Aneurysms ____

SYSTEM REVIEW: (Please circle all that apply)

GENERAL: Fever, Chills or Sweats, Fatigue, Headaches.

EYES: Visual loss or double vision.

Caffeinated Soda ________________ Chocolate ___________________

How many per day? ______________ Qty per week? _______________

Heart Disease _______ High Blood Pressure _______ Diabetes _______

Cancer ______ Blood Clotting Disorder ______ Other ______

Parkinson's Disease ____

ENT: Hearing loss or ringing in ear. Difficulty speaking or difficulty swallowing.

CARDIOVASCULAR: Syncope (passing out). Chest pain, Cyanosis (blue discoloration to skin, clubbing or edema).

RESPIRATORY: Exertional shortness of breath. Shortness of breath. Wheezing or asthma symptoms.

GI: Nausea, vomiting, diarrhea, constipation. URINARY: Painful urination, unusual urination at night, symptoms of infection.

MUSCULOSKELETAL: Acute swelling, myalgias, cramping.

ENDOCRINE: Intolerance to heat/cold, excessive thirst, excessive urination.

SKIN: Hives, Rash.

PSYCHIATRIC: Psychotic thoughts or hallucinations. Depression or anxiety. Sleep problems.

HEME/LYMPH: Abnormal bleeding or abnormal clotting.

Disclaimer: We do not diagnose or treat any medical condition or disease. Our services are for health maintenance only. Nothing in the information provided is intended to treat or cure disease or to replace conventional medical approaches.