CONFIDENTIAL PERSONAL HEALTH HISTORY:

YOUR NAME: _____ **TODAY'S DATE:** _____
DATE OF BIRTH: _____ **CURRENT AGE:** _____

Please describe your primary health concern in coming to see me. If you're currently in pain, fill out the Pain History Page in addition to the following health history.

If you wish to type out a health timeline separate from this form, or if more space is required to cover your history, feel free to use an extra sheet. Of particular interest to me are head traumas and birth trauma, accidents and injuries, hospitalizations and surgeries, significant infections, and known toxic exposures.

1. **Birth to Age One:** Describe what you know about your own birth. Including any details like the use of forceps, vacuum extraction, C-section, long labor, rapid labor, induced labor, maternal smoking, drinking, or drug use (prescription or non-prescription), given up for adoption, parents going through traumatic events during your pregnancy, etc.

2. **Age One to Twelve:** Describe any childhood health issues including normal childhood illnesses, disease diagnosis, injuries, (sports injuries, car accidents, concussions, falls) hospitalizations, surgeries, mental health issues, medications prescribed for any length of time or repeatedly, or any significant life trauma.

3. **Age Twelve to Twenty:** Describe any health information as in #2. Include anything significant about puberty for you – your high school experience, graduating from high school, and your college experience if you went to college.

4. **Age Twenty to Thirty:** Same as above.

5. **Age Thirty to Forty:** Same as above.

6. **Age Forty to Fifty:** Same as above.

7. **Age Fifty to Sixty**: Same as above.

8. **Sixty and Above**: Same as above.

Please list your **doctor-prescribed medications**, the dose you're on, which doctor prescribed it, and the reason your doctor prescribed this particular medication. Please list any medication that you have been on for any extended period of time, even if you're not currently taking it. Note if you have any medication allergies or have ever had an adverse reaction to a medication. List nutritional supplements on the next page.

Please list any **over-the-counter medications** that you use, either occasionally or routinely. (For example: Tylenol, Aspirin, Ibuprofen, Claritin, Zyrtec, Prilosec or other antacids, etc.) For how long?

QUALITY OF LIFE QUESTIONS:

Please list any **nutritional supplements** you take, approximate dosage, and to the best of your ability, the reason that you choose to take them. If they have been prescribed for you, tell me who prescribed them.

HOW YOU SLEEP:

Tell me about the quality of your sleep:

Can you fall asleep easily?

Can you stay asleep?

If you wake up, can you fall back to sleep easily?

Do you have to get up at night?

How many hours of sleep is a typical night for you?

Have you ever been diagnosed with a sleep disorder – or prescribed sleep medication or devices to assist sleep like a CPAP machine or dental appliance?

Have you ever tried nutritional supplements for improving quality of sleep? If so, which ones and did they help you?

WHAT YOU DRINK:

Please list the beverages that you drink. Include what type and amount per day or week.

WATER:

COFFEE OR TEA:

ALCOHOL:

SODA/POP/JUICE – or OTHER:

WHAT YOU EAT: Please list a typical day's meals for you.

Do you have a regular pattern of eating?

Are there any foods you are avoiding, either due to intolerance or for other reasons? If so, what are they and how long have you been avoiding them?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

Please report on any other lifestyle factors that may influence your health for good or for ill.

Do you smoke? Have you ever smoked? How much do you/did you smoke?

Do you exercise? Tell me your history as it relates to exercise.

Do you travel in foreign countries? Have you ever become ill in a foreign country – or after coming back from a foreign country? How much have you traveled?

Do you know of any exposure to chemicals? Are you aware of any chemical exposure – think farm-related fertilizers, pesticides, herbicides, antibiotics, personal yard or garden chemicals, heavy metal exposure, military service exposures, occupational hazards, etc.

Do you know of any exposure to fungus, molds, or yeast?

FAMILY HEALTH HISTORY: If known, please list the major health issues, (diseases, surgeries, illnesses, syndromes, accidents and cause of death, if deceased) for your Mother, Father, Grandparents, and Siblings. If you don't have any family health information, just skip this page.

MOTHER:

FATHER:

MOTHER'S MOTHER:

MOTHER'S FATHER:

FATHER'S MOTHER:

FATHER'S FATHER:

SIBLINGS:

CHILDREN'S HEALTH ISSUES: