

**CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

What are the concerns for which you are seeking care? (Primary concern first)

- 1. \_\_\_\_\_ Date of onset: \_\_\_\_\_
- 2. \_\_\_\_\_ Date of onset: \_\_\_\_\_
- 3. \_\_\_\_\_ Date of onset: \_\_\_\_\_

Are you seeking primary care from Elixia Wellness Group?  Yes  No

If No, who is your primary care physician? \_\_\_\_\_  
(Name) (Phone if known)

For what concern did you last receive health or medical care? \_\_\_\_\_

**Medications and Supplements**

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? \_\_\_\_\_

Check each that you currently use:

- |                |                        |                     |                    |
|----------------|------------------------|---------------------|--------------------|
| Laxatives      | Pain relievers         | Antacids            | Cortisone          |
| Antibiotics    | Heart/Blood medication | Allergy Medication  | Thyroid medication |
| Sleeping pills | Anti-depressants       | Birth Control Pills | Hormones           |

Do you have any known contagious diseases at this time? Yes No If yes, what? \_\_\_\_\_

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

- |                         |                           |                      |
|-------------------------|---------------------------|----------------------|
| Cancer _____            | Diabetes _____            | Epilepsy _____       |
| Heart Disease _____     | High Blood Pressure _____ | Stroke _____         |
| Anemia _____            | Kidney Disease _____      | Glaucoma _____       |
| Allergies _____         | Asthma _____              | Mental Illness _____ |
| Arthritis _____         | Tuberculosis _____        | Alzheimer's _____    |
| Other Conditions: _____ |                           |                      |

**Have you have any of the following Childhood Illnesses (check if yes)**

Scarlet fever  Diphtheria  Rheumatic fever  Mumps  Measles  German measles

Have you had negative reactions to immunizations? Yes No \_\_\_\_\_

**Hospitalizations, Surgery, X-Ray and Special Studies**

What hospitalizations, surgeries, x-rays, or special studies have you had?

\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_ year: \_\_\_\_\_

**Allergies**

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

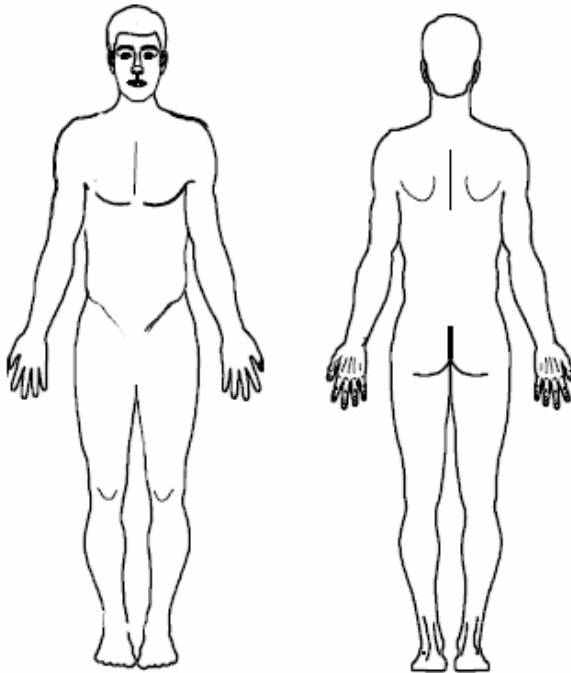
\_\_\_\_\_

**General**

Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_ lbs.  
Maximum Weight \_\_\_\_\_ lbs. When \_\_\_\_\_ Blood Type \_\_\_\_\_

**Review of Symptoms**

Please shade in areas where you are experiencing pain on figures (if applicable).



**LIFESTYLE HABITS (Check applicable)**

- \_\_\_ Main interests and hobbies? \_\_\_\_\_
- \_\_\_ Exercise, what kind? \_\_\_\_\_
- \_\_\_ How often do you exercise? \_\_\_\_\_
- \_\_\_ Average 6-8 hrs. of sleep
- \_\_\_ Have a supportive relationship
- \_\_\_ History of abuse
- \_\_\_ Major traumas
- \_\_\_ Use recreational drugs
- \_\_\_ Treated for drug dependence
- \_\_\_ Drink coffee
- \_\_\_ Drink black or green tea
- \_\_\_ Drink cola or other sodas
- \_\_\_ Add salt to your food
- \_\_\_ Eat refined sugar
- \_\_\_ Enjoy your work
- \_\_\_ Take vacations
- \_\_\_ Spend time outside
- \_\_\_ Watch TV? How much? \_\_\_\_\_
- \_\_\_ Read? How often? \_\_\_\_\_
- \_\_\_ Use alcoholic beverages # per week \_\_\_\_\_
- \_\_\_ Treated for alcoholism
- \_\_\_ Use tobacco currently
- \_\_\_ Used tobacco in the past How long? \_\_\_\_\_
- \_\_\_ How many packs per day? \_\_\_\_\_
- \_\_\_ Have a religious/spiritual practice

**Check any of the following you have or have had in the past 6 months.**

**SKIN**

- \_\_\_ Rashes
- \_\_\_ Eczema, Hives
- \_\_\_ Acne, Boils
- \_\_\_ Itching
- \_\_\_ Fungal Infections
- \_\_\_ Color change
- \_\_\_ Hair Loss
- \_\_\_ Dry skin / scalp
- \_\_\_ Lumps
- \_\_\_ Night Sweats
- \_\_\_ Slow healing ulcerations
- \_\_\_ Flushing or hot flashes

**NOSE AND SINUSES**

- \_\_\_ Frequent colds
- \_\_\_ Nose Bleeds
- \_\_\_ Stuffiness
- \_\_\_ Hay fever
- \_\_\_ Sinus problems
- \_\_\_ Loss of smell

**HEAD / NECK**

- \_\_\_ Headache/migraine
- \_\_\_ Faintness
- \_\_\_ Dizziness
- \_\_\_ Jaw Pain
- \_\_\_ Swollen Glands
- \_\_\_ Goiter
- \_\_\_ Pain or stiffness

**RESPIRATORY**

- \_\_\_ Chest congestion
- \_\_\_ Wheezing
- \_\_\_ Asthma
- \_\_\_ Difficulty/Pain breathing
- \_\_\_ Shortness of breath
- \_\_\_ Cough \_\_\_ Wet or \_\_\_ Dry
- \_\_\_ Coughing blood

**IMMUNE**

- \_\_\_ Chronic Fatigue Syndrome
- \_\_\_ Chronic infections
- \_\_\_ Chronically swollen glands
- \_\_\_ Slow wound healing

**MUSCLES / JOINTS/ BONES**

- \_\_\_ Joint pain
- \_\_\_ Muscle pain
- \_\_\_ Muscle spasms / cramps
- \_\_\_ Restless leg Syndrome
- \_\_\_ Sciatica

**NEUROLOGIC**

- \_\_\_ Seizures
- \_\_\_ Paralysis
- \_\_\_ Muscle weakness
- \_\_\_ Numbness or tingling
- \_\_\_ Easily stressed
- \_\_\_ Vertigo or dizziness
- \_\_\_ Loss of balance

**MOUTH AND THROAT**

- \_\_\_ Sore throat
- \_\_\_ Copious saliva
- \_\_\_ Teeth grinding
- \_\_\_ Sore tongue/lips
- \_\_\_ Gum problems
- \_\_\_ Hoarseness

**Review of Symptoms**

**Check any of the following you have or have had in the past 6 months.**

**EYES AND EARS**

- Itchy eyes
- Watery eyes
- Dry eyes
- Swollen/painful eyes
- Red Eyes
- Impaired vision/Blurriness
- Floaters in vision
- Cataracts
- Color blindness
- Double Vision
- Glaucoma
- Hearing difficulty
- Ringing
- Earaches/Infection

**CARDIOVASCULAR**

- Heart disease
- Angina/Chest pain
- High/Low Blood Pressure
- Murmurs
- Blood clots
- Irregular heart beat
- Palpitations/Fluttering
- Swelling in ankles

**CIRCULATION**

- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Varicose veins
- Cold hands/feet

**ENDOCRINE**

- Hypothyroid
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger
- Seasonal depression

**DIGESTION**

- Trouble swallowing
- Heartburn / Acid Reflux
- Change in thirst/appetite
- Ulcer
- Nausea/Vomiting
- Gas/Bloating
- Belching or passing gas
- Diarrhea
- Constipation
- Pain or cramps
- Mucous in stools
- Black / Bloody stool
- Hemorrhoids
- Itchy / Burning Anus
- Rectal Pain
- Jaundice (yellow skin)
- Bowel Movements: How often? \_\_\_\_\_
- Is this a change? \_\_\_\_\_
- Stools  Hard  Firm
- Soft  Loose

**URINARY**

- Pain on urination
- Increased frequency
- Frequency at night
- Frequent infections
- Inability to hold urine
- Kidney stones
- Blood in urine

**MENTAL/ EMOTIONAL**

- Mood Swings
- Anxiety or nervousness
- Considered/Attempted suicide
- Depression
- Poor concentration
- Poor Memory
- Other: \_\_\_\_\_

**GENERAL**

- Poor Sleep / Insomnia
- Fatigue / Low Energy
- Chills or Fevers
- Cravings \_\_\_\_\_
- Peculiar taste in mouth
- Low Libido
- Experience High Stress

**FEMALE ONLY**

- Irregular cycles
- Bleeding between cycles
- Pain during intercourse
- Clotting
- Heavy or excessive flow
- PMS
- Endometriosis
- Difficulty conceiving
- Painful menses
- Vaginal discharge? Color?
- Vaginal Odor
- Ovarian cysts
- Menopausal symptoms
- Abnormal PAP
- Sexually transmitted disease
- Breast pain/tenderness
- Nipple discharge
- Breast Lumps
- Age at which menses began \_\_\_\_\_
- Age of last menses (if menopausal) \_\_\_\_\_
- Cycle Length (Day 1 to Day 1) \_\_\_\_\_
- Duration of Flow \_\_\_\_\_
- Date of last period \_\_\_\_\_
- Are you sexually active? Yes No
- Sexual orientation? \_\_\_\_\_
- Birth control? Type? \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of live births \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_
- Number of abortions \_\_\_\_\_
- Difficult or premature births
- Do you do breast self-exams? Yes No
- Date of last Pap smear \_\_\_\_\_
- Date of last mammogram \_\_\_\_\_
- Could be pregnant now?
- Any other feminine difficulties?

**MALE ONLY**

- Hernias
- Testicular masses
- Testicular pain
- Prostate disease
- Sexually transmitted disease
- Discharge or sores
- Sexual dysfunction
- Are you sexually active? Yes No
- Sexual orientation? \_\_\_\_\_
- Birth control? Type?

### Context of Care Overview

We would like to take this moment to welcome you to our practice. Whether you were referred by another practitioner for a one-time visit, or are looking for a longer-term comprehensive health solution, we look forward to our role in your care. Below are a few questions that really assist us in understanding “where you’re coming from” and how we can best support your health.

- 1) How did you discover our clinic and how did you decide to see us now?
  
- 2) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)  
0%    **0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**    100%

If you answered less than “10”, what stands between your current commitment and 100%?

- 3) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)
  
- 4) What do you love most about your life at this time?
  
- 5) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)
  
- 6) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?
  
- 7) What are your top three expectations of us?