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 _____

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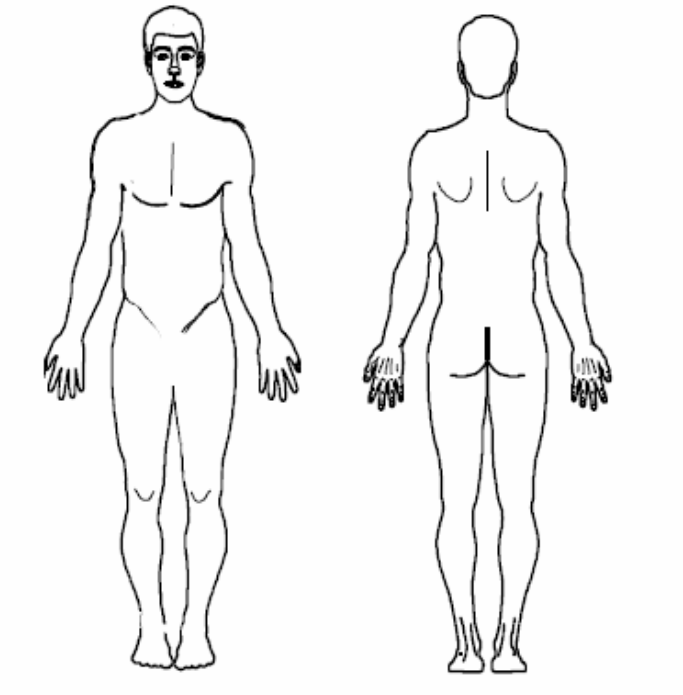
Name: _____ Date: _____

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

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Name: _____ Date: _____

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?

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Name: _____ Date: _____

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?

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