Health and Well Being History Long Form

Name: Date: Address:

Date of birth: Phone:

Referred by: Email:

Describe the problem (s) for which you seek therapy. Include dates when the each problem or injury occurred:

Past medical history (previous injuries, accidents, surgeries, etc please describe and include approximate dates):

List the medications (including over the counter) you are presently taking:

Have you ever had this problem before? If so, when?

What are your goals for treatment?

Please list any other kind of health care professional you are seeing for this problem:

List any medical tests and results you have had within the past year:

Medical History

Please mark the circle that best describes the frequency you experience the below conditions.

1. Rarely (once a month or less)
2. Occasionally (less than once a week)
3. Frequently (more than once a week)
4. Constantly

***Leave BLANK if not ever a problem**

Digestion

(Stomach/Spleen)					
1 2 3 4	Loose stools or Diarrhea	1 2 3 4	Acid reflux	1 2 3 4	Stomach or Intestinal pain
1 2 3 4	Constipation	1 2 3 4	Hiatal Hernia	1 2 3 4	Heartburn
1 2 3 4	Poor digestion	YES NO	Nausea / vomiting	1 2 3 4	Excessive appetite
YES NO	Parasites	1 2 3 4	Gas or belching	1 2 3 4	Poor appetite
(Colon)					
1 2 3 4	Irritable bowels	1 2 3 4	Blood in stools	1 2 3 4	Black or dark stools
1 2 3 4	Hemorrhoids				
(Liver/ Gall Bladder)					
1 2 3 4	Light colored stools	1 2 3 4	Difficulty digesting oily foods	YES NO	High cholesterol
1 2 3 4	Hemorrhoids			YES NO	Gall stones

Respiratory

(Lung)					
1 2 3 4	Wet cough	1 2 3 4	Poor sense of smell	YES NO	Pneumonia
1 2 3 4	Dry cough	1 2 3 4	Sinus problems	YES NO	Asthma
1 2 3 4	Chest tightness	1 2 3 4	Allergies	YES NO	Emphysema
1 2 3 4	Shortness of breath	1 2 3 4	Hay fever	YES NO	Bronchitis
1 2 3 4	Congestion	1 2 3 4	Catches colds easily	YES NO	Do you smoke? Number per day: _____
1 2 3 4	Wheezing	1 2 3 4	Other: _____		
1 2 3 4	Nasal problems	1 2 3 4	Other: _____		

Cardiovascular

(Heart)					
YES NO	Hypertension	1 2 3 4	Restless	YES NO	Poor blood clotting
YES NO	Hypotension	1 2 3 4	Heart palpitation	1 2 3 4	Other: _____
1 2 3 4	Chest pain	1 2 3 4	Slow heart rate	YES NO	Heart disease
1 2 3 4	Dizziness	YES NO	Poor circulation	YES NO	Phlebitis
1 2 3 4	Easily bruised	YES NO	Blood clots	YES NO	Heart attack, quantity? ____
1 2 3 4	Edema	1 2 3 4	Sweaty hands/feet	YES NO	Stroke, quantity? ____
1 2 3 4	Cold hands/feet	YES NO	Anemia		

Urinary

(Kidney/Bladder)					
1 2 3 4	Painful urination	1 2 3 4	Ringing in ears	YES NO	Kidney stones
1 2 3 4	Incontinence	1 2 3 4	Ear aches	YES NO	Kidney infections
1 2 3 4	Difficulty with urination	YES NO	Hearing impairment	YES NO	Low back pain
		1 2 3 4	Other: _____	YES NO	Knee problems

Medical History (Continued)

Nervous System

1 2 3 4	Shaky	YES NO	Epilepsy	YES NO	Developmental or growth problems; type? _____
YES NO	Dyslexia	YES NO	Head injury		
YES NO	Learning disorder	YES NO	Numbness; where? _____		
YES NO	Multiple Sclerosis	YES NO	Tingling; where? _____	YES NO	Nervous disorder; type? _____
YES NO	Muscular Dystrophy	YES NO	Other: _____		

Muscle/Joints

1 2 3 4	TMJ pain	1 2 3 4	Joint swelling	Check Painful Areas			
1 2 3 4	Facial pain	YES NO	Osteoarthritis	R L	Shoulder	R L	Neck
1 2 3 4	Loss of balance	YES NO	Rheumatoid Arthritis	R L	Arm	R L	Upper back
1 2 3 4	Poor Coordination	YES NO	Broken bones or fractures; where? _____	R L	Elbow	R L	Mid back
YES NO	Poor posture			R L	Hands	R L	Low back
1 2 3 4	Leg weakness			R L	Hip	Limitation of movement; where? _____ _____	
1 2 3 4	Arm weakness	YES NO	Metal fixation; where? _____	R L	Legs		
1 2 3 4	Trunk weakness			R L	Knees		
1 2 3 4	Difficulty walking	YES NO	Artificial joints	R L	Feet		

Other

1 2 3 4	Insomnia	1 2 3 4	Fatigue	YES NO	Fibromyalgia
1 2 3 4	Depression	1 2 3 4	Difficulty with speech	YES NO	Poor sense of smell
YES NO	Sleep too much; how long? _____	1 2 3 4	No thirst	YES NO	Poor sense of taste
		1 2 3 4	Excessive thirst	YES NO	Cancer; where? _____ _____
1 2 3 4	Shaky	1 2 3 4	Dry mouth		
1 2 3 4	Poor memory	1 2 3 4	Pain at night		
1 2 3 4	Difficulty paying attention	1 2 3 4	Headaches	YES NO	Allergies (list) _____ _____ _____
1 2 3 4	Anxiety	1 2 3 4	Migraines		
1 2 3 4	Easily angered	1 2 3 4	Eye pain		
1 2 3 4	Tendency to be obsessive in work or relationships.	1 2 3 4	Dry Eyes	YES NO	Hepatitis; type? _____
		1 2 3 4	Watery Eyes	YES NO	Infectious disease; explain _____ _____
1 2 3 4	Difficulty making plans or decisions	YES NO	Other Eye problems: _____		
1 2 3 4	Dizziness	YES NO	Dental problems	YES NO	Herpes
YES NO	Soft or brittle nails	YES NO	Candida	YES NO	Shingles
1 2 3 4	Intolerance to temperature or weather	YES NO	Difficulty swallowing	YES NO	Chemical dependency (drugs or alcohol)?
		YES NO	Diabetes		
1 2 3 4	Fever	YES NO	Weight gain	YES NO	Skin Condition; explain: _____ _____
1 2 3 4	Chills	YES NO	Weight loss		
1 2 3 4	Nose bleeds	YES NO	Tuberculosis		
1 2 3 4	Swollen glands	YES NO	Thyroid problems	YES NO	Other: _____

Medical History (Continued)

* Men Only

1 2 3 4	Prostate problems	1 2 3 4	Pain associated with genitals	YES NO	Other: _____
YES NO	Prostate cancer	1 2 3 4	Impotence		_____
1 2 3 4	Problems urinating	YES NO	Infertility		

* Women Only

1 2 3 4	Breast pain or tenderness	YES NO	Are your cycles regular; length of cycle? _____	YES NO	Endometriosis
YES NO	Breast lumps			YES NO	PMS
YES NO	Nipple discharge	YES NO	Painful menses?	YES NO	Infertility
YES NO	Menopause	YES NO	Heavy or excessive flow?	YES NO	Other: _____
YES NO	Menopausal symptoms (list) _____	YES NO	Painful intercourse		_____
		YES NO	Ovarian cysts		

Well Being

Please circle any of the following feelings you have experienced in the last few months.

Abused	Overwhelmed	Agitated	Panic
Criticized	Muddled	Uneasy	Intolerant
Overworked	Persecuted	Distress	Uncertainty
Paralyzed	Guilty	Fearful	Aggravated
Depressed	Easily irritated	Impatient	Annoyed
Rejected	Anxious	Intimidated	Angry
Despair	Sad	Restless	Outraged
Helpless	Grieving	Paranoid	Nervous
Hopeless	Unable to grieve	Apprehensive	Worried
Numb			

Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	◯ none	◯ minimal	◯ moderate	◯ severe
My relationship stress is	◯ none	◯ minimal	◯ moderate	◯ severe
My work stress is	◯ none	◯ minimal	◯ moderate	◯ severe
My financial stress is	◯ none	◯ minimal	◯ moderate	◯ severe
My health stress	◯ none	◯ minimal	◯ moderate	◯ severe
Other stress _____	◯ none	◯ minimal	◯ moderate	◯ severe
Other stress _____	◯ none	◯ minimal	◯ moderate	◯ severe
Other stress _____	◯ none	◯ minimal	◯ moderate	◯ severe

How much time do you have for yourself to relax and what do you do to relax ie. hobbies, meditation, etc…?

_____

_____

Do you exercise? And if so what kind and how often?

_____

_____

How many hours a night do you sleep? _____ Is your sleep restful? _____ If not, describe:

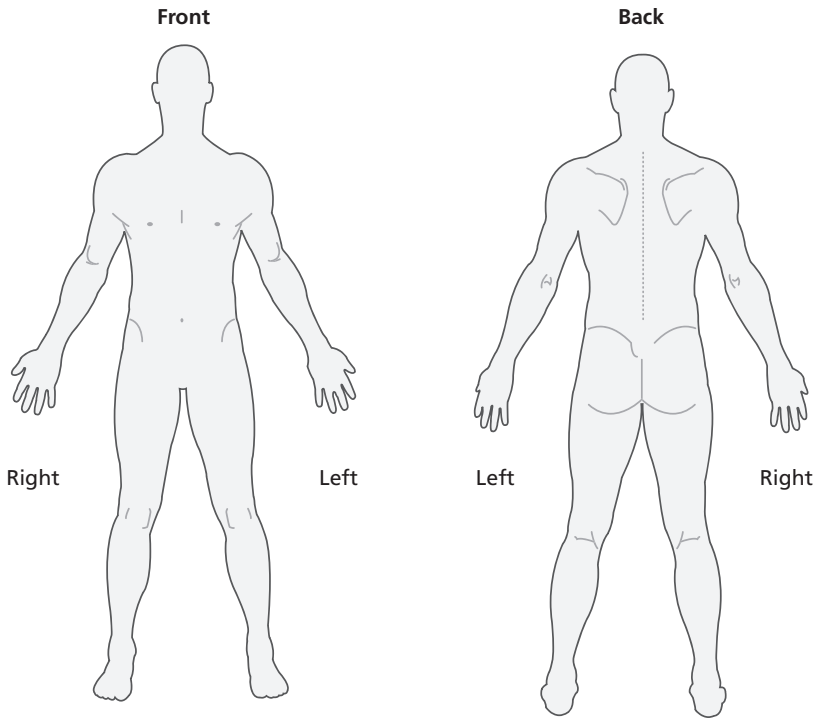
_____

_____

Well Being (Continued)

Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.	1 Slight awareness of discomfort 2-3 Awareness of discomfort as an aggravation 4-6 Pain is strong but you are still functional 7-9 Pain is so strong you are unable to function normally 4-6 Pain is strong but you are still functional 10 You feel like you need to go to the emergency room.
1 2 3 4 5 6 7 ● 9 10 Example: back	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.



Comments

Practitioner's comments:

Client signature: Date:

Practitioner signature: Date: