Countryside Wellness Center

Confidential Health History Questionnaire Date:_____

We look forward to helping you achieve your health goals. Please help us learn more about you so that we may provide you with the most effective care. On this questionnaire, you will find many in-depth questions; each answer provides important information that allows us to optimize your health care results. Thank you for your thorough responses.

Last Name	First Name	Middle Initial

Street Address	City	State	Zip

Home Phone	Cell Phone	Date of Birth	Age	Sex	Marital Status

Work Phone	Employer	Occupation

In Emergency Notify	Their Phone	Their Relationship to you

Your E-mail Address (if you would like to receive articles, newsletters or be informed of events.)

Primary Medical Doctor	City	Their Phone

Name of patients, relatives, friends, or doctors who referred you to us.

Other ways you have heard of us: lectures, fliers, radio, newspaper, yellow pages, other ads, etc.

List your reasons for coming to see us, summarizing any health concerns that you have.

What treatments have you tried for these conditions?

Height	Weight	Blood Pressure	Date of this BP reading	Blood Type

Please identify current symptoms by marking the box under the "Now" column.
Then, rate the intensity of the symptom by circling 1 for the least severe and 5 for the most severe.
Mark a box under the past column only if a past condition was particularly severe or significant.

Past	Now		Severity
☐	☐	Abdominal / stomach pain	1 2 3 4 5
☐	☐	Abnormal appetite	1 2 3 4 5
☐	☐	Belching	1 2 3 4 5
☐	☐	Black stool	1 2 3 4 5
☐	☐	Blood in stool	1 2 3 4 5
☐	☐	Constipation	1 2 3 4 5
☐	☐	Diarrhea	1 2 3 4 5
☐	☐	Heartburn / reflux	1 2 3 4 5
☐	☐	Gas	1 2 3 4 5
☐	☐	Mucous in stool	1 2 3 4 5
☐	☐	Nausea	1 2 3 4 5
☐	☐	Overweight	1 2 3 4 5
☐	☐	Rectal pain	1 2 3 4 5
☐	☐	Regular laxative use	1 2 3 4 5
☐	☐	Unusually thirsty	1 2 3 4 5
☐	☐	Undigested food in stool	1 2 3 4 5
☐	☐	Vomiting	1 2 3 4 5
☐	☐	Weight changes	1 2 3 4 5
☐	☐	Bleeding / bruising easily	1 2 3 4 5
☐	☐	Bleeding gums	1 2 3 4 5
☐	☐	Cold hands / feet	1 2 3 4 5
☐	☐	Chest pain / pressure	1 2 3 4 5
☐	☐	Dizzy spells or fainting	1 2 3 4 5
☐	☐	Irregular heart beat	1 2 3 4 5
☐	☐	Palpitations/ chest fluttering	1 2 3 4 5
☐	☐	Poor circulation	1 2 3 4 5
☐	☐	Pounding heart beat	1 2 3 4 5
☐	☐	Racing heart beat	1 2 3 4 5
☐	☐	Chronic cough	1 2 3 4 5
☐	☐	Coughing blood	1 2 3 4 5
☐	☐	Frequent chest colds	1 2 3 4 5
☐	☐	Shortness of breath	1 2 3 4 5
☐	☐	Tightness of chest	1 2 3 4 5
☐	☐	Wheezing	1 2 3 4 5
☐	☐	Chronic or recurrent infection	1 2 3 4 5
☐	☐	Fatigue or tiredness	1 2 3 4 5
☐	☐	Sudden energy drop (time of day _____)	

Past	Now		Severity
☐	☐	Chills	1 2 3 4 5
☐	☐	Excessive sweating	1 2 3 4 5
☐	☐	Fever	1 2 3 4 5
☐	☐	Hot flashes	1 2 3 4 5
☐	☐	Lack of perspiration	1 2 3 4 5
☐	☐	Night sweats	1 2 3 4 5
☐	☐	Tendency to be too hot	1 2 3 4 5
☐	☐	Tendency to be too cold	1 2 3 4 5
☐	☐	Dry eyes	1 2 3 4 5
☐	☐	Dry mouth or throat	1 2 3 4 5
☐	☐	Earaches	1 2 3 4 5
☐	☐	Eye pain	1 2 3 4 5
☐	☐	Facial pain	1 2 3 4 5
☐	☐	Frequent or extended hoarseness	1 2 3 4 5
☐	☐	Frequent sore throat	1 2 3 4 5
☐	☐	Headaches	1 2 3 4 5
☐	☐	Hearing problems	1 2 3 4 5
☐	☐	Itchy eyes	1 2 3 4 5
☐	☐	Jaw Problems or TMJ	1 2 3 4 5
☐	☐	Many cavities or root canals	1 2 3 4 5
☐	☐	Mouth or lip sores	1 2 3 4 5
☐	☐	Night or color blindness	1 2 3 4 5
☐	☐	Nose bleeds	1 2 3 4 5
☐	☐	Poor vision	1 2 3 4 5
☐	☐	Ringing or sounds in ears	1 2 3 4 5
☐	☐	Sinus problems	1 2 3 4 5
☐	☐	Sneezing	1 2 3 4 5
☐	☐	Snoring	1 2 3 4 5
☐	☐	Swollen glands	1 2 3 4 5
☐	☐	Tearing eyes	1 2 3 4 5
☐	☐	Teeth grinding or clenching	1 2 3 4 5
☐	☐	Unusual taste in mouth	1 2 3 4 5
☐	☐	Blood in urine	1 2 3 4 5
☐	☐	Burning or painful urination	1 2 3 4 5
☐	☐	Difficult urination / retention	1 2 3 4 5
☐	☐	Frequent or urgent urination	1 2 3 4 5
☐	☐	Frequent urination at night	1 2 3 4 5
☐	☐	Loss of bladder control	1 2 3 4 5

Past	Now		Severity
☐	☐	Anger	1 2 3 4 5
☐	☐	Anxiety	1 2 3 4 5
☐	☐	Depression	1 2 3 4 5
☐	☐	Fear	1 2 3 4 5
☐	☐	Frustration	1 2 3 4 5
☐	☐	Grief or sadness	1 2 3 4 5
☐	☐	Irritability	1 2 3 4 5
☐	☐	Mood swings	1 2 3 4 5
☐	☐	Obsession	1 2 3 4 5
☐	☐	Panic Attacks	1 2 3 4 5
☐	☐	Stress	1 2 3 4 5
☐	☐	Worry	1 2 3 4 5

☐	☐	Back pain or trouble	1 2 3 4 5
☐	☐	Muscle spasm or cramps	1 2 3 4 5
☐	☐	Muscle pain	1 2 3 4 5
☐	☐	Muscle weakness	1 2 3 4 5
☐	☐	Pain of feet	1 2 3 4 5
☐	☐	Restless or nervous legs	1 2 3 4 5
☐	☐	Spinal disc problems	1 2 3 4 5
☐	☐	Stiff or painful neck	1 2 3 4 5
☐	☐	Swelling	1 2 3 4 5
☐	☐	Tendonitis (where:_____)	

Other pain (list locations):

Past	Now		Severity
☐	☐	Acne pimples	1 2 3 4 5
☐	☐	Dry skin	1 2 3 4 5
☐	☐	Itching or burning skin	1 2 3 4 5
☐	☐	Skin rash , psoriasis or eczema	1 2 3 4 5
☐	☐	Skin sores	1 2 3 4 5
☐	☐	Dandruff or flaking	1 2 3 4 5
☐	☐	Early graying of hair	1 2 3 4 5
☐	☐	Loss of hair	1 2 3 4 5
☐	☐	Nail fungus	1 2 3 4 5
☐	☐	Weak / brittle nails	1 2 3 4 5

☐	☐	Numbness or tingling	1 2 3 4 5
☐	☐	Poor concentration	1 2 3 4 5
☐	☐	Poor memory	1 2 3 4 5
☐	☐	Seizures or convulsions	1 2 3 4 5
☐	☐	Shaking or trembling	1 2 3 4 5
☐	☐	Stuttering or stammering	1 2 3 4 5

☐	☐	Difficulty sleeping	1 2 3 4 5
☐	☐	Night heat or sweats	1 2 3 4 5
☐	☐	Many dreams	1 2 3 4 5
☐	☐	Wake up still tired	1 2 3 4 5

FOR MEN

☐	☐	Genital pain, swelling or itching	1 2 3 4 5
☐	☐	Impotence	1 2 3 4 5
☐	☐	Low sperm count	1 2 3 4 5
☐	☐	Penile discharge	1 2 3 4 5
☐	☐	Prostate problem (_____)	

FOR WOMEN

Past	Now		Past	Now		Past	Now	
☐	☐	Abnormal PAP smear	☐	☐	Endometriosis	☐	☐	Pain with intercourse
☐	☐	Abnormal sex drive	☐	☐	Fibroids	☐	☐	Painful periods
☐	☐	Abortion	☐	☐	Heavy bleeding with periods	☐	☐	Pelvic inflammatory disease
☐	☐	Bleeding between periods	☐	☐	Hysterectomy	☐	☐	Polycystic ovary disease
☐	☐	Breast lumps / tenderness	☐	☐	Menopausal symptoms	☐	☐	Premenstrual tension / PMS
☐	☐	Clots in menstrual blood	☐	☐	Miscarriage	☐	☐	Vaginal discharge
☐	☐	Difficulty conceiving	☐	☐	Ovaries removed	☐	☐	Vaginal dryness

Duration of periods:	Number of pregnancies you've had:
Interval between periods:	Number of births you've had:
Dates of last period:	Ages of your children:
Past birth control methods:	Current birth control method:

Check if you have had any of these:

Past	Now		Past	Now		Past	Now	
☐	☐	Addiction (to _____)	☐	☐	Fibromyalgia	☐	☐	Mononucleosis
☐	☐	AIDS / HIV	☐	☐	Gall bladder disease / stones	☐	☐	Multiple sclerosis
☐	☐	Allergies	☐	☐	German measles	☐	☐	Mumps
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Osteoporosis / osteopenia
☐	☐	Arthritis	☐	☐	Gum disease	☐	☐	Pleurisy
☐	☐	Asthma	☐	☐	Heart disease	☐	☐	Pneumonia
☐	☐	Bleeding disorder	☐	☐	Hemorrhoids	☐	☐	Polio
☐	☐	Blood clots	☐	☐	Hepatitis or jaundice	☐	☐	Rheumatic fever
☐	☐	Bronchitis	☐	☐	Herpes	☐	☐	Scarlet fever
☐	☐	Cancer / tumor	☐	☐	High / Low blood pressure	☐	☐	Shingles
☐	☐	Cataracts	☐	☐	High cholesterol	☐	☐	Spinal meningitis
☐	☐	Chicken pox	☐	☐	Kidney stones	☐	☐	Stroke
☐	☐	Chronic fatigue syndrome	☐	☐	Kidney or bladder infection	☐	☐	Tuberculosis
☐	☐	Colon / bowel disease	☐	☐	Liver disease	☐	☐	Thyroid trouble or goiter
☐	☐	Diabetes	☐	☐	Lupus	☐	☐	Ulcer
☐	☐	Emotional / mental problem	☐	☐	Malaria	☐	☐	Varicose veins
☐	☐	Emphysema	☐	☐	Measles	☐	☐	Venereal disease

Other specific illnesses:

Surgeries, hospitalizations & dates:	Accidents, injuries & dates:	Current medicines, dosages & reasons:

Check if you have a FAMILY HISTORY of any of these:

☐ Allergies	☐ Epilepsy	☐ Mental illness
☐ Arthritis	☐ Glaucoma	☐ Problems with alcohol or drugs
☐ Asthma	☐ Gout	☐ Stroke
☐ Bleeding disorders	☐ Heart disease	☐ Thyroid disease
☐ Cancer	☐ High blood pressure	☐ Other inheritable disease:
☐ Diabetes	☐ Kidney disease	

By signing this form, I attest that all information I have provided on this Health History is accurate and complete. I also give consent for treatment with the therapies offered at Countryside Wellness Center, including acupuncture, massage, herbs, homeopathic remedies and/or nutritional supplements. And, I understand that if I wish to change the dosages of my current medications, this should happen gradually and under the care of all my physicians.

Sign:	**Date:**