

Health History Form - 2017

Date Completed: _____

Patient Name _____ Gender: M or F

If minor, Parent(s) Full Name: _____

Address: _____

Height: _____

Weight: _____

Pt Occupation: _____

Pt Birthdate: _____

Phone: _____

Is this?: Patient Parent

Email: _____

Is this?: Patient Parent

1. Education: (Last grade completed) _____

2. Significant birth events _____

3. Injuries _____

4. Surgeries _____

5. Pregnancies _____

6. Allergies to ragweed, pollen, grasses? _____

7. Food or Chemical Sensitivities? _____

8. Previous Medications (No longer taking) _____

9. Primary Diagnosis/es _____

10. Present Treatment Approach _____

11. Please describe your diet _____

12. What are some of your favorite foods? _____

13. Do you often get sleepy after meals? Yes _____ No _____

14. Sleep problems? _____

15. Do you usually recall dreams? _____

16. Do you smoke cigarettes? _____ How many daily? _____

17. Do you drink alcohol? _____ How frequently? _____

18. Did/Do you enjoy school? Yes _____ No _____

19. Typical grades in school: A B C D F

20. Favorite subjects _____

21. Difficult subjects _____

22. Tendency for Anger: High _____ Average _____ Low _____

23. Tendency for Anxiety: High _____ Average _____ Low _____

24. Hobbies? _____

Sports? _____

25. Do you experience depression? Often _____ Sometimes _____ Never _____

26. Pain threshold: High _____ Average _____ Low _____

27. Do you function well under stress? Yes _____ No _____

28. Are you competitive at sports? Very _____ Average _____ No _____

29. Did you continue to grow taller after age 16? Yes _____ No _____

30. Ever married? _____ Children? _____

If a female, how many times were you pregnant? _____

Please Circle the Symptoms or Traits that Apply to You

- poor stress control
- sensitivity to bright lights
- morning nausea
- tendency to delay or skip breakfast
- very dry skin
- pale skin, inability to tan
- high irritability and temper
- history of underachievement
- little or no dream recall
- autoimmune disorders
- white spots on fingernails
- ringing in the ears
- history of perfectionism
- stretch marks (striae) on skin
- severe depression
- fear of airplane travel, tornadoes, etc.
- obsessions with negative thoughts
- delayed puberty
- dark or mauve-colored urine
- abnormal EEG
- sleep problems
- social isolation
- dry eyes and mouth
- poor short-term memory
- sensitivity to loud noises
- affinity for spicy and salty foods
- tendency to be overweight
- obsessive/compulsive tendencies
- extreme mood swings
- history of a reading disorder
- severe inner tension
- frequent infections
- premature graying of hair
- competitive in sports
- poor muscle development
- "fruity" breath and/or body odor
- spleen-area pain
- severe anxiety
- very strong willed
- joint pains
- poor wound healing
- psoriasis
- tendency to stay up very late
- seasonal allergies (ragweed, pollens, etc)
- enjoys spicy foods
- artistic or musical ability

Medical History

Primary Symptoms: _____

Onset of condition: _____

Treatments that are or were effective: _____

Treatments that failed: _____

Any family members with similar symptoms? _____

Please circle any of the following that apply to a relative:

temper tantrums

ADD/ADHD

cancer

panic disorder

anxiety disorder

dementia

asthma

ulcers

heart disease

stroke

bipolar disorder

kidney problems

depression

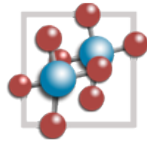
autism

psoriasis

diabetes

arthritis

schizophrenia



WALSH RESEARCH INSTITUTE
Better Health through Biochemistry

NAME: _____ Date of Birth: _____

DATE COMPLETED: _____

List all tablets/capsules, patches, drops, ointments, injections, etc. **currently taking**. **Include prescription, over-the-counter, herbal, vitamin, etc.** Please also list and note any medicine you take only on occasion.

Medication	Brand/Generic Name	Dosage and How Often	Reason for Taking	Date Started

MEDICATION LIST (Con't)

Medication	Brand/Generic Name	Dosage and How Often	Reason for Taking	Date Started