Health Fitness Vitality Client Information

1. PERSONAL INFORMATION

Name____
Date of birth______________________________ Age_________
Address:
Street____
City_________________________State________Zip code______
Phone (day)________________________(evening)____________
Occupation____
Marital status____
Children (#/ages) _______________________________________

NOTE: this is a confidential record of your medical history and will be kept confidential. Information herein will not be released to any person unless you have authorized us to do so.

What are the major concerns for seeking a consultation today? _________________
____
____
When did this begin? ____
____
Has anything recently changed or become worse? ____________________________________
____
Have you had a diagnosis? If so, what was it, how was it arrived at, and by whom? ________
____
Are you currently receiving care from any other health professional?
(Name)____
What condition(s)?____
Are you currently taking any medications, prescription or otherwise? YES_____ NO_____
Please list them: ____
____
Do you have any infectious diseases that you know of? YES_____ NO_____
If yes, please list them: ____
Are you pregnant? YES_____ NO_____
If yes, how many months? _______
Do you have any known allergies or sensitivities? If so, please list them:
____
____
Is there any reason why you could not take remedies made in alcohol?
____
Have you ever been hospitalized or had any surgeries? If so, please note date and reason:
____
____

2. FAMILY MEDICAL HISTORY

Please complete this section only for family members with particular health problems.

Father____
Mother____
Brothers____
Sisters____
Children____
Other close blood relatives____
Comments____

3. PERSONAL HEALTH HABITS

Height __________ Current weight__________ Weight 1 year ago__________
Do you smoke? ______ How many years?__________ Amount daily______________
Do you drink alcohol?______ What?____________ Frequency? ________________
Do you use recreational drugs?______ What?__________ Frequency?_________
Do you drink coffee? ______ How much?__________ Tea?_______ How much?____
Do you exercise regularly? ___ Frequency?__________________
Type?_______________________________ Duration?_______________________

4. HEALTH CONCERNS

Check off any experienced in the last three months.

SKIN & HAIR

- ❑ Rashes ❑ Itching ❑ Dandruff ❑ Change in skin texture
- ❑ Hair Loss ❑ Hives ❑ Pimples ❑ Moles
- ❑ Eczema ❑ Poor Healing sores ❑ Other: __________

HEAD, EYES, EARS, NOSE, & THROAT

- ❑ Poor vision ❑ Earaches ❑ Ringing in ears ❑ Cold sores
- ❑ Facial pain ❑ Sinus congestion ❑ Ear infections ❑ Spots in front of eyes
- ❑ Cataracts ❑ Blurred vision ❑ Sore throat ❑ Grinding teeth
- ❑ Glaucoma ❑ Dizziness ❑ Mucous in throat ❑ Clicking jaw
- ❑ Eye pain ❑ Poor hearing ❑ Canker sores ❑ Nose bleeds
- ❑ Swollen glands ❑ Frequent colds ❑ Other:

CARDIOVASCULAR

- ❑ High blood pressure ❑ Irregular heart beat ❑ Cold hands or feet
- ❑ Low blood pressure ❑ Fainting ❑ Chest pain
- ❑ Palpitations ❑ Other:

RESPIRATORY

- ❑ Cough ❑ Coughing blood ❑ Bronchitis ❑ Pneumonia
- ❑ Asthma ❑ Pain on breathing ❑ Shortness of breath without exertion
- ❑ Difficulty breathing when lying down ❑ Production of phlegm YES / NO If yes, what color?_____________
- ❑ Other:

GASTROINTESTINAL

- ❑ Nausea ❑ Constipation ❑ Abdominal pain ❑ Blood in stools
- ❑ Hemorrhoids ❑ Food cravings ❑ Difficulty swallowing ❑ Vomiting
- ❑ Black stools ❑ Indigestion ❑ Mucous in stools ❑ Gas
- ❑ Poor appetite ❑ Diarrhea ❑ Bad breath ❑ Heartburn
- ❑ Rectal pain ❑ Bloating ❑ Food allergies ❑ Other:
- ❑ # of bowel movements daily ______ ❑ Loose / Normal / Hard?

URINARY

- ❑ Painful urination ❑ Urinary urgency ❑ Incontinence ❑ Frequent urination
- ❑ Kidney stones ❑ Inability to hold urine ❑ Blood in urine ❑ Irregular flow
- ❑ Decreased flow ❑ Difficulty starting/stopping slow ❑ Other:

MUSCULOSKELTEAL

- ❑ Neck pain ❑ Back pain ❑ Muscle pain ❑ Muscle weakness
- ❑ Stiffness ❑ Reduced range motion ❑ Other:

Do you see a chiropractor or massage therapist? (name) _______________________________

REPRODUCTIVE

Age at first menses: _______ Length of cycle: __________ Duration of bleeding: _____

- ❑ Heavy bleeding ❑ Pain with intercourse ❑ Unusual bleeding ❑ Cramps
- ❑ Discharge ❑ Irregular cycles ❑ Breast lumps ❑ Clots

PMS? If yes, what symptoms? ____

____

Date and result of last pap smear____

____

# of pregnancies _______ Premature births _______ # of births _______

Abortions _______ # of Miscarriages _________ Onset of menopause ______

Type of birth control used____

____

Any other gynecological problems?____

____

NEUROPSYCHOLOGICAL

- ❑ Poor sleep ❑ Depression ❑ Seizures ❑ Headaches
- ❑ Lack of coordination ❑ Poor memory ❑ Irritability ❑ Difficulty concentrating
- ❑ High stress levels ❑ Loss of balance ❑ Numbness ❑ "Spacey"/foggy feeling
- ❑ Migraine ❑ Anxiety ❑ Other: ❑ Hours of sleep per 24 hours: _______

GENERAL

- ❑ Fatigue ❑ Night sweats ❑ Slow metabolism ❑ Fevers
- ❑ Excessive thirst ❑ Chills ❑ Intolerance to heat/cold
- ❑ Sudden energy drops ❑ Other:

THANK YOU!

NOTES: