



Health History Summary

Date _____

Name _____ Age _____ Birthday _____ Blood Type _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (work) _____ daytime or evening? _____

Occupation _____ (full or part time?) Employer _____

Insurance Co. _____ Policy # _____ Soc Sec # _____

Address _____ City _____ State _____ Zip _____

Nearest Relative _____ Phone _____ Relationship _____

Who else can we reach in case of emergency?

Name _____ Phone _____ Relationship _____

How did you hear about the Palmer Center for Natural Healing? _____

Last physician or health practitioner seen? _____ When? _____

When was your last blood test? _____ What kind? _____

Your Current Health Problems

What is your main reason for coming in today? If you have a specific health condition please describe in detail. When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation.

List in order of importance other health problems that are troubling you:

- 1.) _____ & Length of time _____
- 2.) _____ & Length of time _____
- 3.) _____ & Length of time _____
- 4.) _____ & Length of time _____

Other Problems: _____

How long has your main problem been troubling you? _____

Is your current "main problem" getting (*better, worse, same*) and for how long? _____

What kind of treatment have you received and from whom? _____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem (*Yes or no*) or for any problem? (*Yes or no*).

What was the therapy and what were the results? _____

Your Health History

The general state of your health is:

(Excellent _____) (Good _____) (Average _____) (Fair _____) (Poor _____)

Describe your energy level on average from 1 –10 (10 being highest): _____

When during the day is your energy the best? _____ Worst? _____

What is your current approximate weight? _____ Height? _____ Weight 1 yr ago? _____

As an adult, what has been your maximum weight? _____ Minimum _____

Do not include pregnancy

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (*Yes or no*) Please circle

- 1.) _____ Date _____
- 2.) _____ Date _____
- 3.) _____ Date _____
- 4.) _____ Date _____
- 5.) _____ Date _____

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? _____ Have you in the past? _____ If so when? (Date) _____

Are you currently working with a Doctor of conventional medicine? (M.D. or D.O) (*Yes or No*)

What childhood illnesses have you had? (check off if had)

Measles _____	mumps _____	Chickenpox _____	Whooping cough _____
Polio _____	Diphtheria _____	Rheumatic fever _____	Scarlet fever _____
Small pox _____	Typhoid fever _____	tuberculosis _____	Mono _____ (how long) _____

Pervious surgeries and hospitalizations (include dates) _____

Which of the following have you had, indicate "now or past", also how often and when?

Now or past	year	Now or past	year	Now or past	year
____ Pneumonia _____		____ Diabetes _____		____ Gonorrhea _____	
____ Tonsillitis _____		____ Asthma _____		____ Syphilis _____	
____ Ear Infections _____		____ Eczema _____		____ Venereal Disease _____	
____ Chronic Infections _____		____ Heart Disease _____		____ Epilepsy _____	
____ Canker Sores _____		____ Herpes _____		____ High Blood Pressure _____	
____ Allergies _____		____ Hepatitis _____		____ Mononucleosis _____	
____ Thyroid problems _____		____ Weight Problem _____		____ Anemia _____	
____ Others _____					

Do you have any allergies to any drugs, herbs, foods, animals or other? (Y or N) What? _____

Which of the following do you currently use? (Please state the amount, how often, and how long)

Alcohol _____ Tobacco _____
Hormones _____ Coffee _____
Cortisone _____ Laxatives _____
Sedatives _____ Antacids _____

Other Medication (please give full name, dosage and how long you have been taking the medication)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Vitamins/ Herbs (please give full name, dosage and how long you have been taking the medication)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Family History

	Living (age?)	Health Problems	Died (age?)	Cause
Your Mother	_____	_____	_____	_____
Your Father	_____	_____	_____	_____
Your Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Your Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Mother's Mom	_____	_____	_____	_____
Mother's Dad	_____	_____	_____	_____
Father's Mom	_____	_____	_____	_____
Father's Dad	_____	_____	_____	_____

What is your nationality? (Please list all backgrounds and give approximate %) _____

You currently live with? Spouse _____ Partner _____ Parents _____ Friends _____ Children _____ Alone _____

Are you? Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ in a supportive relationship _____

What is your current level of education? _____ Are you satisfied with this? (Yes or No)

De you have any children? _____ How many? _____ Ever have Toxemia during peg. (Y or N)

Do they have any health problems? _____

Do you have any blood relatives (aunts, uncles, grandparents) who have had any of the following?

_____ Allergies _____ Arthritis _____ Asthma _____ Cancer _____ Diabetes

Anemia Depression Skin Disease Heart Attack Genetic Prob.
 High B.P. Stroke Ulcers Cataracts Thyroid Prob.
 Hypoglycemia Seizures Sickle Cells Venereal Disease

What is your weakest organ system and why? _____

Personal Habits

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry most about in life? _____

Do you exercise? (Y or N) If yes what kind, how much & how often? _____

Do you have a religious or spiritual practice? (Y or N) If yes, what? _____

On a scale of 1-10, how would you rate the quality of your sleep? (10 being great) _____

Any problems falling/staying asleep? (Y or N) How many hours do you sleep at night? _____

Do you awaken at night? (Y or N) If yes, what time(s) do you usually wake up? _____

Do you sweat while sleeping? (Y or N) How frequently and how much do you sweat? _____

Do you wake up feeling refreshed? (Y or N)

Do you nap or rest horizontally throughout the day? (Y or N) For how long? _____

Do you feel you have a (warm, cool or average) temperature when you wake up?

Do you feel your (hands or feet) are (warm, cool or average) temperature generally?

Do you enjoy your work? (Y or N) Do you take vacations? (Y or N)

Are you now in a happy, satisfying relationship with someone? (Very, mostly, somewhat, not)

How often do you get colds, flu's, sore throat, or yeast infections during the year? _____

When you rise quickly from a sitting or lying position do you ever get dizzy? (Y or N)
 If yes, how often? (daily, few times per week, 1xWeek, 2xMonth, 1xMonth, rarely)

Female Reproduction

Age of first menses? _____ If periods have stopped, at what age did they stop? _____

Are your cycles regular (Y or N) Periods begin every _____ days. For _____ many days.

Are your periods (heavy, medium, light) & what color is the blood? (light red, med. , dark red, clots)

Do you have spotting or bleeding between periods? (Y or N) Any cramp with periods? (Y or N)

Do you have any premenstrual symptoms? (water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings, or other: _____)

Number of pregnancies _____ Number of abortions _____ Number of live births? _____

Number of miscarriages _____ Any problems getting pregnant? _____

Do you get yearly PAP smears? (Y or N) Any abnormal PAP's (Y or N) Breast Lumps? (Y or N)

Are you currently sexually active? (Y or N) How often? _____ Is this (more or less) than 1 yr ago?

Do you use birth control? (Y or N) What type of birth control do you currently use?

Have you ever been physically or sexually abused? (Y or N) How old and how often? _____

Male Reproduction

How often do you urinate at night? _____ Has this increased in the past few years? (Y or N)

Do you have any problems with impotency? (Y or N) Do you have any sores on penis? (Y or N)

Do you have any abnormal discharge from the penis? (Y or N) Any venereal disease? (Y or N)

Any prostate problems? (Y or N, past/now) Ever have an examination? (Y or N) When? _____

Are you currently sexually active? (Y or N) How often? _____ Is this (more or less) than 1 yr ago?

Do you use birth control? (Y or N) What type of birth control do you currently use? _____

Have you ever been physically or sexually abused? (Y or N) How old and how often? _____

Digestion and Elimination

Digestion

Do you have any problems with gas, bloating or fullness after eating? (Y or N)

How often does this occur? (often, sometimes, never) How severe? _____

Do you have gas in (the upper part of the abdomen, the lower part, or both parts)?

How long have you had this problem? _____

How often do you have bowel movements? _____

Do you ever have any (blood, mucus, undigested food, black stools)?

Do you have any rectal itching? (Y or N) Do your stools tend to be (formed or loose)?

How often do you have diarrhea? _____

Do you ever have alternating constipation and diarrhea? (Y or N)

How often do you have thin, long and narrow stools? (often, sometimes, never)

How often do you have small and hard stools? (often, sometimes, never)

Do you ever have yellow or light colored stools? (often, sometimes, never)

How often do your stools have a strong disagreeable odor? (often, sometimes, never)

Have you ever fasted? (Y or N; Juice or water) For how long did you fast? _____

How did you feel while you were fasting? _____

Traveled outside the U.S. in the last 5 years? (Y or N) Camping in the last 5 years? (Y or N)

Kidneys and Bladder

Have you had recurrent bladder infections? (Y or N) How were they treated? _____

How many bladder infections have you had in the last 3 years? _____

Do you have any burning sensations during or after urination? (past or present)

Is your urine (dark yellow, bright yellow, cloudy, pale or clear)?

Does your urine have a strong odor (Y or N) Any difficulty starting/stopping urinating? (Y or N)

Any difficulty perspiring? (Y or N) Do you perspire when exercising? (lightly, moderately, heavily)

Do you perspire other times than when exercising? (Y or N) When? _____

Does your perspiration have a strong smell? (Y or N)

Does your temperature tend to run (low, average or high)?

Occupational/household

How long have you lived at your present address? _____ Where have you lived previously? _____ (Please describe location. I.e.: old/new, construction, damp, moldy)

Do you have specialized air filtration at home? (Y or N) Do you live in the city? (Y or N)

Do you work in an office building? (Y or N) Do the windows open? (Y or N)

Do you have specialized air filtration at work? (Y or N)

Do you work in the presence of toxic fumes of chemicals? (Y or N)

Do any of your hobbies involve toxic materials? (Y or N)

Are you exposed to second hand smoke currently? (Y or N)

What do you use for your drinking water? (bottled, filtered or tap water)

Do you have anything else you would like to comment on? _____

