MCBRIDE HEALING, LLC

Health History Questionnaire

Name ______________________________ Date ____/_____/______

Please complete this questionnaire as thoroughly as possible.

Which condition is your primary reason for coming in for treatment?
How can we help you today:

Date of initial onset:

Cause of onset:

Aggravating factors:

Alleviating factors:

How much do your symptoms interfere with work, rest, hobbies, etc. on a scale of 1 to 10 (10 = worst)?
1 2 3 4 5 6 7 8 9 10

Past Medical History (Please include month/year when the diagnosis was established)

Fibromyalgia	Tuberculosis	Hypertension	Heart Disease	Arthritis
Breathing Problems	Emotional Imbalance	Venereal Disease	Digestion	Arthritis
HIV +/ AIDS	Thyroid	Anemia	Seizures	Other

Surgeries:
Hospitalization:
Significant Trauma (Auto, Sports, Divorce, etc.)
Allergies (drugs, chemicals, foods):

Family History:
Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

Condition	Father	Mother	Brothers	Sisters	Child	Spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age at death						
Cause of death						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Height _______ Current Weight ______lb. Maximum Weight ______lb. When? _______

Childhood Illnesses:

Scarlet Fever	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Diphtheria	Yes	No
Measles	Yes	No
Pneumatic fever	Yes	No
German Measles	Yes	No

Immunizations:

Measles/Mumps/Rubella	Yes	No
Tetanus	Yes	No
When? _______		
Pertussis	Yes	No
Polio	Yes	No
Diphtheria	Yes	No
Other	Yes	No

Allergies:
Are you hypersensitive or allergic to:
Any Drugs? □ Yes □ No Please List:
____
____
Any Foods? □ Yes □ No Please List:
____
____

Current Medications:
Please list any prescription medications, over the counter medications, vitamins, or other supplements you are currently taking (use back of page if needed):
____
____
____
____
____
____
____
____

Symptom Profile:
For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

Skin disorders:

Currently Have?	■YES	■PAST	When?
Acne, Boils	□	□	___________
Acute Hair Loss	□	□	___________
Color Change	□	□	___________
Eczema, Hives	□	□	___________
Itching	□	□	___________
Nail Fungus	□	□	___________
Psoriasis	□	□	___________
Rash	□	□	___________
Other___________	□	□	___________

Respiratory System Disorders:

Currently Have?	■YES	■PAST	When?
Bronchitis	□	□	___________
Chronic Asthma	□	□	___________
Chronic Cough	□	□	___________
Emphysema	□	□	___________
Frequent Colds	□	□	___________
Pain in Breathing	□	□	___________
Pneumonia	□	□	___________
Shortness of Breath	□	□	___________
Sinus Congestion	□	□	___________
Spitting Up Blood	□	□	___________
Temporary Cough	□	□	___________
Tuberculosis	□	□	___________
Other __________	□	□	___________

Emotional or Mental Illness:

Currently Have?	■YES	■PAST	When?
Anxiety	□	□	___________
Depression	□	□	___________
Considered or Attempted Suicide	□	□	___________
Irritability	□	□	___________
Mood Swings	□	□	___________
Other	□	□	___________

Head, Ear, Eyes, Nose, Throat:

Currently Have?	■YES	■PAST	When?
Head:			
Headaches	□	□	___________
Location: ______________________________			
Migraines	□	□	___________
Head Injury	□	□	___________
Hay Fever	□	□	___________
Ears:			
Earaches	□	□	___________
Ringing in Ears	□	□	___________
Impaired Hearing	□	□	___________
Dizziness	□	□	___________
Eyes:			
Cataracts	□	□	___________
Color Blindness	□	□	___________
Contacts or Glasses	□	□	___________
Double Vision	□	□	___________
Eye Pain or Strain	□	□	___________
Glaucoma	□	□	___________
Impaired Vision	□	□	___________
Tearing or Dryness	□	□	___________
Spots in Front of Eyes	□	□	___________
Nose:			
Nose Bleeds	□	□	___________
Loss of Smell	□	□	___________
Nasal Drainage to Throat	□	□	___________
Other___________	□	□	___________
Mouth:			
Bleeding Gums	□	□	___________
Dental Cavities	□	□	___________
Dry Mouth	□	□	___________
Oral Sores	□	□	___________
Teeth Grinding	□	□	___________
Jaw Problems, TMJ	□	□	___________
Burning Mouth	□	□	___________
Throat:			
Goiter	□	□	___________
Hoarseness	□	□	___________
Swollen Glands	□	□	___________
Trouble Swallowing	□	□	___________
Neck Pain/ Stiffness	□	□	___________
Frequent Sore Throat	□	□	___________
Other	□	□	___________

Digestive System Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Nausea	□	□	________
Vomiting	□	□	________
Loss of Appetite	□	□	________
Ulcer	□	□	________
Heartburn	□	□	________
Gas or Bloating	□	□	________
Internal Cramping	□	□	________
Constipation	□	□	________
Diarrhea	□	□	________
Loose Stool	□	□	________
Hemorrhoids	□	□	________
Bowel movement frequency?			________
- Is this a change?	□	□	________
Other________	□	□	________

Cardiovascular Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Heart Disease	□	□	________
Endocarditis	□	□	________
Chest Pain	□	□	________
Heart Murmur	□	□	________
Palpitations or Fluttering	□	□	________
High Blood Pressure	□	□	________
Low Blood Pressure	□	□	________
Phlebitis	□	□	________
Blood Clots	□	□	________
Ankle Swelling	□	□	________
Fainting	□	□	________
Other________	□	□	________

Urinary Tract Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Frequent Infection	□	□	________
Frequent Night Urination	□	□	________
Inability to Hold Urine	□	□	________
Burning or Pain During Urination	□	□	________
Increased Frequency	□	□	________
Kidney Stones	□	□	________
Other________	□	□	________

Musculoskeletal Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Weakness	□	□	________
Muscle Spasms or Cramps	□	□	________
Joint Pain, Swelling, or Stiffness	□	□	________
Sciatica	□	□	________
Fibromyalgia	□	□	________
Broken Bones	□	□	________
Any Other Pain	□	□	________
Location: ________________			
Other ________	□	□	________

Lifestyle Habits:

Do You….	**■ No**	**■ Yes**
Exercise?	□ No	□ Yes
What Kind? ________________		
How Often? ________________		
Take Vacations?	□ No	□ Yes
How Often? ________________		

Sleep Habits:

Do You….	**■ No**	**■ Yes**
Sleep Well?	□ No	□ Yes
Awaken Rested?	□ No	□ Yes
Average 6-8 Hours Sleep?	□ No	□ Yes
Spend Time Outside?	□ No	□ Yes

What time of day is your energy at its best?

____

Tobacco, Food and Drink Habits:

Do you…	**■ No**	**■ Yes**
Use Tobacco?	□ No	□ Yes
How Much/How often? ________________		
Smoked Previously?	□ No	□ Yes
How Long? ________________		
How many packs per day? ________________		
Ever been treated for drug dependence?	□ No	□ Yes
Drink Alcohol?	□ No	□ Yes
How much? ________________		
Drink Caffeinated Beverages?	□ No	□ Yes
How often? ________________		

General Health:

Currently Have?	■YES	■PAST	When?
Easy Bleeding or Bruising	□	□	___________
Varicose Veins	□	□	___________
Anemia	□	□	___________
Slow Wound Healing	□	□	___________
Chronic Infections	□	□	___________
Day Sweats	□	□	___________
Night Sweats	□	□	___________
Cold Hands or Feet	□	□	___________
Heat or Cold Intolerance	□	□	___________
Fatigue	□	□	___________
Chronic Fatigue Syndrome			
Hypoglycemia	□	□	___________
Hyperthyroid	□	□	___________
Excessive Thirst	□	□	___________
Excessive Hunger	□	□	___________
Diabetes	□	□	___________
Gallbladder Disease	□	□	___________
Liver Disease	□	□	___________
Jaundice	□	□	___________
Hepatitis	□	□	___________
- Type? ___________________________________			
Other___________	□	□	___________

Any History of Psychological, Physical or Sexual Abuse? □ No □ Yes

____

Typical Food Intake:

Breakfast ___________________________________

Lunch ______________________________________

Dinner _____________________________________

Snacks______________________________________

How many meals do you eat per day? ___________

Go on diets often? □ No □ Yes

Eat out often? □ No □ Yes #s/week______

FOR MEN ONLY:

Do you now, or have you ever had…?			When?
Testicular Masses	□ No	□ Yes	___________
Testicular Pain	□ No	□ Yes	___________
Prostate Disease	□ No	□ Yes	___________
Impotence	□ No	□ Yes	___________
Premature Ejaculation	□ No	□ Yes	___________
Hernias	□ No	□ Yes	___________
Genital, Oral or Rectal Herpes	□ No	□ Yes	___________
Other STD	□ No	□ Yes	___________
Other __________	□ No	□ Yes	___________

FOR WOMEN ONLY:

Do you now, or have you ever had…?
When?

Breast Lumps	□ No	□ Yes	___________
Nipple Discharge	□ No	□ Yes	___________
Breast Tenderness	□ No	□ Yes	___________
Cervical Dysplasia	□ No	□ Yes	___________
Vaginal Discharge	□ No	□ Yes	___________
Genital, Oral or Rectal Herpes	□ No	□ Yes	___________
Other STD	□ No	□ Yes	___________
Fibroids	□ No	□ Yes	___________
Ovarian Cysts	□ No	□ Yes	___________
Sexual Difficulties	□ No	□ Yes	___________
Are you sexually active?	□ No	□ Yes	___________
Birth control use?	□ No	□ Yes	___________
Number of Pregnancies			___________
Number of Live Births			___________
Number of Miscarriages			___________
Number of Abortions			___________
Age at first menses			___________
Length of cycle in days			___________
Duration of period in days			___________
PMS Symptoms	□ No	□ Yes	___________
Painful Menses	□ No	□ Yes	___________
Clotting during menses	□ No	□ Yes	___________
Bleeding between periods	□ No	□ Yes	___________
Menopausal symptoms	□ No	□ Yes	___________
Other __________	□ No	□ Yes	___________