10216 63rd Ave. So., Seattle, WA 98178
206.661.9586 · www.joycegreenberg.com

Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often, minor symptoms are major clues to delicate somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized me to do so.

Health History Questionnaire

Date _____

Name Address	
Home Phone	Work Phone
Date of Birth Age	Occupation
Height Weight	Family Physician
Referred By	e-mail address:

What is/are the main problem/s you would like me to help you with? _____

_____

_____

When did it begin? (Date)_____Describe what caused it: _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

Have you been advised to have any surgery which was not done?_____

What kinds of treatment/medicine have you tried? _____

_____

_____

Past Medical History (please include date)

☐ Cancer ☐ High Blood Pressure ☐ Thyroid Disease _____ ☐ Jaundice_____
☐ Diabetes ☐ Heart Disease ☐ Seizures _____ ☐ Pneumonia_____
☐ Hepatitis ☐ Rheumatic Fever ☐ Venereal Disease _____ ☐ TB_____
☐ Other _____

Surgeries (type and date) _____

_____

Significant Trauma (physical or emotional -auto accidents, falls, divorce, death in family, abuse etc.) **Include date**.

_____

_____

Significant Dental Work (type and date) _____

Birth History (prolonged labor, forceps delivery, etc.) _____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History ☐Diabetes ☐High Blood Pressure ☐Stroke ☐Asthma
☐Cancer ☐Heart Disease ☐Seizures ☐Allergies
☐Other _____

Medicines taken within the last two months (medications, vitamins, herbs, etc).

_____

_____

_____

Occupational Stress (chemical, physical, psychological, etc.) _____

_____

Do you have a regular exercise program? ☐Yes ☐No Please describe_____

Please describe the emotions or mind states (examples: anger, fear, grief, sadness, joy, over thinking, frustration, etc) that seem predominant in your life (frequently experienced, difficult to express or overcome, or in any way influential).

_____

_____

Have you ever been on a restricted diet? ☐Yes ☐No What kind and when?_____
Any peculiar taste in mouth_____ Any particular food cravings_____

Please describe your last three meals:

Morning _____
Afternoon_____Snacks_____
Evening _____Snacks_____
How many packs of cigarettes do you smoke per day? _____How much alcohol do you drink per day?_____
How much coffee, tea or cola do you drink per day? _____Marijuana or drugs_____

Please check any symptoms you have had in the last three months:

General
- ☐Chills
- ☐Fevers
- ☐Sweat easily
- ☐Night sweats
- ☐Localized weakness
- ☐Bleed or bruise easily
- ☐Peculiar tastes or smells
- ☐Strong thirst (cold or hot)
- ☐Thirst, no desire to drink
- ☐Fatigue
- ☐Sudden energy drop
  Time of day? _____
- ☐Edema Where? _____
- ☐Poor sleeping
- ☐Tremors
- ☐Poor balance
- ☐Cravings
- ☐Change in appetite
- ☐Poor appetite
- ☐Weight gain
- ☐Weight loss

Skin and Hair
- ☐Rashes
- ☐Itching
- ☐Change in hair or skin
- ☐Ulcerations
- ☐Eczema
- ☐Oozing or skin lesion
- ☐Hives
- ☐Pimples
- ☐Recent moles
- ☐Loss of hair
- ☐Dandruff
- ☐Other hair or skin problems:
  _____

Head, Eyes, Ears, Nose, And Throat
- ☐Dizziness
- ☐Migraines
- ☐Headaches
  When: _____
  Where:_____
- ☐Facial Pain

- ☐Glasses
- ☐Poor vision
- ☐Night blindness
- ☐Blurry vision
- ☐Color blindness
- ☐Blind field
- ☐Spots in front of eyes
- ☐Eye pain
- ☐Eye strain
- ☐Cataracts
- ☐Eye dryness
- ☐Excessive tear
- ☐Discharge from eyes
- ☐Poor hearing
- ☐Ringing in ears
- ☐Earaches
- ☐Discharge from ears
- ☐Nose bleeds
- ☐Sinus congestion
- ☐Nasal drainage
- ☐Grinding teeth
- ☐Teeth problems

- ☐ Jaw Clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips or tongue
- ☐ Other head or neck problems:

_____

_____

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Other heart/vessel problems:

_____

_____

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Pain with a deep breath
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm.
  What color? _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Other lung problems:

_____

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain or cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems _____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake up to urinate?
☐ Yes ☐ No

How often?

_____

Any particular color to your urine?

_____

other genital/urinary system problms?

_____

Pregnancy And Gynecology

Number of pregnancies _____
Number of births _____
Number of premature births___
Number of miscarriages_____
Number of abortions _____
Age at first menses _____
Days between menses _____
Duration of menses (days) ___
First date of last menses:

_____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Menopause:

Age _____
Year _____

- ☐ Vaginal discharge
- ☐ Postcoital bleeding
- ☐ Vaginal sores

Date of last Pap _____

- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?
☐ Yes ☐ No

What type and for how long?

_____

_____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Bad temper
- ☐ Loss of control/violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Seeing a therapist? _____
For how long?_____
Have you ever considered or attempted suicide? _____