HEALTH INVENTORY

Name _____ Today's date_____

Address _____ Birth date _____

City_____State/Zip_____ Age____Sex____Height____Weight____

Phone: W_____H:_____ Legal status: S M D Sep W Kid

e-mail (for notification of classes)_____ Occupation_____

Referred by_____ Education (Years completed) Elem_____

Family Physician _____HS_____Coll_____Voc_____Prof_____

Family History

	Age	Cause of death
Father		
Mother		
Siblings		

Children	Age	Health Problems

Check the items that apply to the **client's blood relatives** mentioned above.

- ☐ Alcohol / drug problem_____
- ☐ Allergy / asthma_____
- ☐ Anemia_____
- ☐ Arteriosclerosis_____
- ☐ Arthritis_____
- ☐ Binge eating / bulimia_____
- ☐ Bleeding_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Epilepsy / seizure_____
- ☐ Heart disease_____
- ☐ High blood pressure_____
- ☐ High cholesterol / fat_____
- ☐ Kidney disease_____
- ☐ Mental illness_____
- ☐ Obesity_____
- ☐ Skin Diseases_____
- ☐ Stroke_____
- ☐ Suicide_____
- ☐ Thyroid disease_____
- ☐ Tuberculosis_____
- ☐ Ulcer_____

Clients Past History of Medical Problems

Surgery, hospitalization approximate dates

_____

_____

_____

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Trauma: accidents, concussions, broken bones

_____ _____

_____ _____

_____ _____

- ☐ Abdominal bloating_____
- ☐ Abdominal pain _____
- ☐ Acne _____
- ☐ Allergies _____
- ☐ Anxiety _____
- ☐ Arteriosclerosis _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Back pain/strain _____
- ☐ Balance problems _____
- ☐ Belching _____
- ☐ Bladder infection _____
- ☐ Bleeding or bruising_____
- ☐ Bleeding gums _____
- ☐ Blood clots _____
- ☐ Bowel Gas _____
- ☐ Breast fed _____
- ☐ Breast lumps _____
- ☐ Bronchitis _____
- ☐ Cancer _____
- ☐ Cataract _____
- ☐ Chest Pain or pressure_____
- ☐ " at rest _____
- ☐ " with exertion _____
- ☐ " with stress _____
- ☐ " with eating _____
- ☐ "down left arm,neck,back____
- ☐ " w /nausea,sweat, anxiety___
- ☐ " irregular heartbeat_____
- ☐ " Palpitations _____
- ☐ " Fast heartbeat _____
- ☐ " Heart murmur _____
- ☐ Cold hands/feet _____
- ☐ Constipation _____
- ☐ Dizziness _____
- ☐ Hair loss / growth _____
- ☐ Change wart/mole _____
- ☐ Chemical sensitive. _____
- ☐ Chicken pox _____
- ☐ Chronic fatigue _____
- ☐ Chronic cough _____
- ☐ Colds, frequent _____
- ☐ Colitis _____
- ☐ Concentration difficult_____
- ☐ Congenital defects_____
- ☐ Dental problems _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Diarrhea _____
- ☐ Ear infections _____
- ☐ Eczema _____
- ☐ Endometriosis _____
- ☐ Epilepsy _____
- ☐ Eye pain _____
- ☐ Eyes tear or itch _____
- ☐ Fainting _____
- ☐ Fibrocystic breasts_____
- ☐ Fibroids _____
- ☐ Frequent infection_____
- ☐ Gallbladder problems_____
- ☐ Glasses /contacts _____
- ☐ Glaucoma _____
- ☐ Gout _____
- ☐ Halos around lights_____
- ☐ Hay fever _____
- ☐ Headaches _____
- ☐ Hemorrhoids _____
- ☐ Hearing Loss _____
- ☐ Hears ringing buzzing_____
- ☐ Heart attack _____
- ☐ Heart failure _____
- ☐ Hemorrhoids _____
- ☐ Hepatitis _____
- ☐ Herpes _____
- ☐ Hiatal Hernia _____
- ☐ High blood pressure_____
- ☐ High cholesterol _____
- ☐ High triglycerides _____
- ☐ Hives _____
- ☐ Hypoglycemia _____
- ☐ Infectious mono. _____
- ☐ Insomnia _____
- ☐ Irritability _____
- ☐ Joint pain _____
- ☐ " worse motion? _____
- ☐ " better motion _____
- ☐ " swollen joints _____
- ☐ " stiff joints _____
- ☐ Kidney infection _____
- ☐ Kidney stones _____
- ☐ Kidney problems _____
- ☐ Light headedness _____
- ☐ Liver disease _____
- ☐ Low back pain _____
- ☐ Measles _____
- ☐ Migraine _____
- ☐ Mood swings _____
- ☐ Mouth breather _____
- ☐ Mumps _____
- ☐ Muscle pain _____
- ☐ " weakness _____
- ☐ Nausea/vomiting _____
- ☐ Nervous cond. _____
- ☐ Neurological problems_____
- ☐ Nightmares _____

- ☐ Night sweats _____
- ☐ Nosebleeds _____
- ☐ Numbness/Tingling_____
- ☐ Overweight(20 lbs)_____
- ☐ Pelvic infection _____
- ☐ Peptic ulcer _____
- ☐ Periodontal disease _____
- ☐ Phlebitis _____
- ☐ Pneumonia _____
- ☐ Poor memory _____
- ☐ Premenstrual tension_____
- ☐ Rectal bleeding _____
- ☐ Restlessness _____
- ☐ Rheumatic fever _____
- ☐ Root canal _____
- ☐ Salivation excess _____
- ☐ Scarlet fever _____
- ☐ Seizure/Convulsion_____
- ☐ S.T.D's _____
- ☐ Shortness of breath_____
- ☐ " with exertion _____
- ☐ " at night _____
- ☐ Sinusitis _____
- ☐ Skin problems _____
- ☐ Sleep disorders _____
- ☐ Sore throats _____
- ☐ Stool is black _____
- ☐ " is clay colored _____
- ☐ " Mucousy _____
- ☐ Stroke _____
- ☐ Suicide attempt _____
- ☐ Swelling feet / legs _____
- ☐ Swollen glands _____
- ☐ Steroid use _____
- ☐ Thyroid problems _____
- ☐ Tonsillitis _____
- ☐ Tooth problems _____
- ☐ Trembling episodes_____
- ☐ Tuberculosis _____
- ☐ Urine - frequent _____
- ☐ " Painful / burning_____
- ☐ " at night _____
- ☐ " blood in urine _____
- ☐ " foul odor to urine_____
- ☐ "loss of urine control_____

MEN

- ☐ Enlarged prostate _____
- ☐ Decreased urine stream_____
- ☐ Unable to interrupt stream__
- ☐ Dribbling after urination____
- ☐ Pus or drainage _____
- ☐ Genital swelling/rash_____
- ☐ Problem w/ sexual function__

WOMEN

- ☐ Usual length of cycle_____
- ☐ Usual length of period_____
- ☐ Age menstruation began_____
- ☐ Age at menopause_____
- ☐ Number of pregnancies_____
- ☐ Number of live births_____
- ☐ # of abortions/miscarriages___
- ☐ Change in cycle _____
- ☐ Spotting between periods___
- ☐ Discomfort with periods____
- ☐ PMS _____
- ☐ Vaginal discharge _____
- ☐ Painful intercourse _____
- ☐ Itching _____
- ☐ Problem w/ sexual function__
- ☐ Lump in breast _____
- ☐ Abnormal pap smear_____
- ☐ Infertility _____
- ☐ Pregnancy complications____
- ☐ Has used birth control _____
- ☐ Used an IUD=type_____

- ☐ **To control weight, I have**
- ☐ fasted longer than 1 day
- ☐ diet pills
- ☐ self-induced vomiting
- ☐ laxatives
- ☐ enemas
- ☐ diuretics (water pills)
- ☐ health / diet
- ☐ exercise

I estimate my use of:

coffee: _____cups / day

tea:_____cups / day

soda:_____cans / day

beer:_____cans / day

wine:____glasses per _____

'hard liquor____oz per_____

marijuana: ___ per_____

I exercise! Yes No

I've been arrested Yes No

Military service? Yes No

I've been a victim of abuse

physical / mental/ emotional

I worry about money / job

family / relationships / world

issues.

I see a Psychotherapist,

M.D./ Psychologist /

Chiropractor./ Osteopath /

Chinese medicine

other_____

Life changes

In the last 12 months, what changes have occurred in your:

1. Current medications including both predcriptions and non prescriptions

_____

_____

_____

2. Allergies including medications, pollens, animals,insects, plants, chemicals

_____

_____

_____

3. Current vitamins, herbs,_____

_____

_____

4. Personal life:_____

_____

_____

5. Family life:_____

_____

_____

6. Social life:_____

_____

_____

7. Work life:_____

_____

_____

8. Sex life:_____

_____

_____

9. What is your life's passion? _____

_____

_____

10. Hobbies, relaxation, recreation: _____

_____

_____