# Santa Monica Healing Arts Center
# Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask.

**Name _____ Date _____**

**Address_____ City_____ State_____ Zip _____**

**Home Phone_____ Mobile_____ email _____**

**Birthdate_____ Occupation_____ How long _____**

**In emergency Phone:**
**notify_____ Phone: _____**

**Primary insurance**
**Carrier_____ Policy#: _____Group#:_____**

**Family physician _____**

**Date symptoms first noticed_____ Work related? _____**

**Is your condition due to an accident? _____**

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## Main problem: What would you like us to help you with?

How long ago did this problem begin (be specific)?

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

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

What kind of treatment have you tried?

## Past Medical History (please include date:)

**Significant Illnesses:** Cancer Diabetes Hepatitis High Blood Pressure
Heart Disease Rheumatic Fever Thyroid Disease Seizures Other

**Surgeries:**

**Significant Trauma (auto accidents, falls, etc.)**

**Allergies: (drugs, chemicals, foods.)**

## Family Medical History:

**Diabetes** **Cancer** **High Blood Pressure** **Seizures** **Asthma** **Allergies**

**Heart Disease** **Stroke**

## Occupation

Occupational stress (chemical, physical, psychological, etc.)

Do you have a regular exercise program? Please describe.

## Medicines taken within the last two months

(Include vitamins, over-the-counter drugs, herbs, etc.)

**Are you or have you ever been on a restricted diet? What kind?**

**Please describe your average daily diet:**

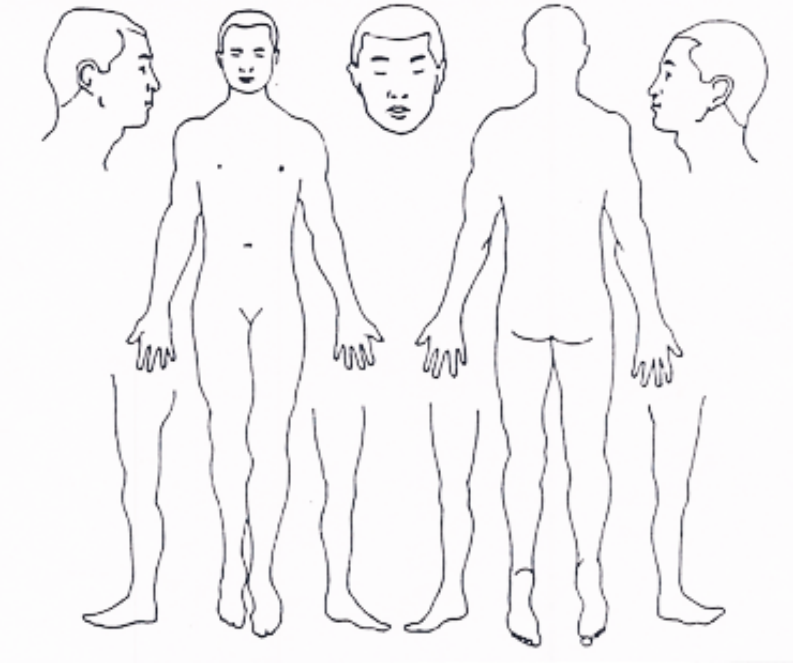
Morning Afternoon Evening

**Habits:**

Cigarettes Coffee Tea Cola Alcohol

Drugs Sugar Salt Other_____

**Indicate painful or distressed areas**



**Please check if you have had (in the last three months):**

## GENERAL

- ❑ Poor Appetite
- ❑ Poor Sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Chills
- ❑ Night Sweats
- ❑ Sweat easily
- ❑ Tremors
- ❑ Cravings
- ❑ Localized weakness
- ❑ Poor balance
- ❑ Change in appetite
- ❑ Bleed or bruise easily
- ❑ Weight loss
- ❑ Weight gain
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot drinks)
- ❑ Sudden energy drop (what time of day?)

## SKIN AND HAIR

- ❑ Rashes
- ❑ Ulcerations
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Loss of Hair
- ❑ Recent moles
- ❑ Change in hair or skin texture

Any other hair or skin problems?

## HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Dizziness
- ❑ Concussions
- ❑ Migraines
- ❑ Glasses
- ❑ Eye Strain
- ❑ Eye Pain
- ❑ Poor vision
- ❑ Night blindness
- ❑ Color blindness
- ❑ Cataracts
- ❑ Blurry vision
- ❑ Earaches
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Spots in front of eyes
- ❑ Sinus problems
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Grinding teeth
- ❑ Facial pain
- ❑ Sores on lips or tongue
- ❑ Teeth problems
- ❑ Jaw clicks

Headaches (Where and When?)
Any other head or neck problems?

**CARDIOVASCULAR**

- ❑ High blood pressure
- ❑ Irregular heartbeat
- ❑ Cold hands or feet
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Dizziness
- ❑ Swelling of hands
- ❑ Phlebitis
- ❑ Chest pain
- ❑ Fainting
- ❑ Swelling of feet
- ❑ Difficulty in breathing

Any other heart of blood vessel problems?

**RESPIRATORY**

- ❑ Cough
- ❑ Bronchitis
- ❑ Production of phlegm What color?
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Asthma
- ❑ Pain with a deep breath

Any other lung problems?

**GASTROINTESTINAL**

- ❑ Nausea
- ❑ Constipation
- ❑ Black stools
- ❑ Bad breath
- ❑ Abdominal pain or cramps
- ❑ Chronic laxative use
- ❑ Vomiting
- ❑ Gas
- ❑ Blood in stools
- ❑ Rectal pain
- ❑ Diarrhea
- ❑ Belching
- ❑ Indigestion
- ❑ Hemorrhoids

Any other problems with your stomach or intestines?

**GENITO-URINARY**

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Decrease inflow
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Impotency
- ❑ Blood in urine
- ❑ Kidney stones
- ❑ Sores on genitals

Do you wake up to urinate? How often?
Any other problems with your genital or urinary system?

**PREGNANCY AND GYNECOLOGY**

_____Number of pregnancies
_____Miscarriages
_____Period between menses
_____Number of births
_____Abortions
_____Duration
_____Premature births
_____Age at first menses
_____First date of last menses

- ❑ Unusual character (Heavy or light)
- ❑ Painful periods
- ❑ Vaginal discharge
- ❑ Changes in body/psyche prior to menstruation
- ❑ Clots
- ❑ Vaginal sores
- ❑ Irregular periods
- ❑ Last PAP
- ❑ Breast lumps

Do you practice birth control? What type and for how long?

**MUSCULOSKELETAL**

- ❑ Neck pain
- ❑ Back pain
- ❑ Hand/wrist pains
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pains
- ❑ Hip pain

Any other joint or bone problems?

**NEUROPSYCHOLOGICAL**

- ❑ Seizures
- ❑ Areas of numbness
- ❑ Concussion
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Depression
- ❑ Loss of Balance
- ❑ Poor memory
- ❑ Anxiety

Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

Please bring your completed form to your first appointment.

Thank you very much,

Santa Monica Healing Arts Center