Health History Form

Please complete these forms and bring them with you to your Initial Consultation. All information provided will be kept confidential unless required by law. Your written permission will be required to release any information.

Date: _____

Name: _____ **Age:** _____ **Male:** ☐ **Female:** ☐

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____ **Date of Birth:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

Emergency Contact: _____ **Phone:** _____

Primary Care Provider: _____ **Phone:** _____

Referred By: _____

Allergies: _____

_____

Height: _____ **Weight:** _____ **Max. Weight:** _____ **When:** _____

Do You Have A Known Contagious Disease At This Time: _____

List Your Most Important Health Issues In Order Of Importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Family Health History (Parents/Siblings): _____

_____

_____

How Is Your General Health Overall: _____

_____

_____

Health History Form

Do You Have Or Ever Had:

Childhood Illnesses

- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella (German Measles)
- ☐ Whooping Cough
- ☐ Chicken Pox
- ☐ Other Childhood Illnesses

Endocrine

- ☐ Diabetes
- ☐ Fatigue
- ☐ Thyroid Problems
- ☐ Adrenal Problems
- ☐ Pituitary Problems
- ☐ Seasonal Affective Disorder
- ☐ Insulin Pump
- ☐ Other Endocrine Issues

Immune

- ☐ AIDS
- ☐ Autoimmune Arthritis
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Fibromyalgia
- ☐ Hepatitis
- ☐ Herpes
- ☐ Lupus
- ☐ Lyme
- ☐ Multiple Sclerosis
- ☐ Parkinsons
- ☐ Tuberculosis
- ☐ Frequent Infections
- ☐ Chronic Infections
- ☐ Swollen Glands
- ☐ Reactions to Vaccines
- ☐ Slow Wound Healing
- ☐ Other Immune Issues

Immunizations

- ☐ Polio
- ☐ Diphtheria
- ☐ Pertussis
- ☐ Tetanus
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Herpes
- ☐ Other Immunizations

Ear / Nose / Mouth / Throat

- ☐ Frequent Colds
- ☐ Frequent Sore Throat
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Hay Fever
- ☐ Loss of Smell
- ☐ Loss of Hearing
- ☐ Ear Infection
- ☐ Teeth Grinding
- ☐ Gum Problems
- ☐ Dental Cavities
- ☐ Crowns / Root Canals
- ☐ Jaw / TMJ Problems
- ☐ Other ENMT Issues

Neck

- ☐ Lumps
- ☐ Goiter
- ☐ Swollen Glands
- ☐ Pain / Stiffness

Urinary

- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Difficulty / Pain With Urination
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ Other Urinary Issues

Mental / Emotional

- ☐ Insomnia
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Bipolar
- ☐ Alzheimers / Dementia
- ☐ Schizophrenia
- ☐ Chronic Stress
- ☐ ADD / ADHD
- ☐ Autism Spectrum
- ☐ Head Injury
- ☐ Memory Problems
- ☐ Other Mental / Emotional Issues

Respiratory

- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Coughing Up Thick Phelgm
- ☐ Chronic Cough / Bronchitis
- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema
- ☐ Pain On Breathing
- ☐ Wheezing
- ☐ Sleep Apnea
- ☐ Other Respiratory Issues

Nervous

- ☐ Epilepsy / Seizures
- ☐ Headaches
- ☐ Migraines
- ☐ Vertigo / Dizziness
- ☐ Fainting
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Muscle Weakness
- ☐ Other Nervous Issues

Health History Form

Do You Have Or Ever Had:

Cardiovascular

- ☐ High / Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Chest Pain / Heart Attack
- ☐ Bleeding / Clotting Problems
- ☐ Varicose Veins
- ☐ Stroke / CVA / TIA
- ☐ Heart Disease
- ☐ Irregular Heart Rate / Murmur
- ☐ Edema
- ☐ Rheumatic Fever
- ☐ Fainting
- ☐ Pacemaker or similar device
- ☐ Anemia
- ☐ Other Cardiovascular Issues

Female Reproductive

- ☐ Regular Cycle
- ☐ Irregular Cycle
- ☐ Length of Cycle____Days
- ☐ Duration of Menses____Days
- ☐ Painful Menses
- ☐ Heavy / Excessive Flow
- ☐ Vaginal Discharge
- ☐ Birth Control
- ☐ Hormone Replacement
- ☐ Pregnancies____
- ☐ Live Births____
- ☐ Miscarriages____
- ☐ Difficulty Conceiving
- ☐ Endometriosis
- ☐ Ovrian Cysts
- ☐ Veneral Disease
- ☐ Herpes
- ☐ Menopausal
- ☐ Post Menopausal
- ☐ Breast Tenderness / Lumps
- ☐ Abnormal PAP
- ☐ Other Female Issues

Musculo-Skeletal

- ☐ Joint Problems
- ☐ Joint Replacement
- ☐ Bone Disease
- ☐ Injuries / Broken Bones
- ☐ General Weakness
- ☐ Muscle Spasms / Cramps
- ☐ Joint Pain / Stiffness
- ☐ Arthritis
- ☐ Sciatica / Backpain
- ☐ Other M-S Issues

Skin

- ☐ Rashes
- ☐ Color Change
- ☐ Night Sweats
- ☐ Eczema / Hives
- ☐ Psoriasis
- ☐ Acne / Boils
- ☐ Open Wounds
- ☐ Lumps
- ☐ Other Skin Issues

Gastrointestinal

- ☐ Swallowing Difficulty
- ☐ Nausea / Vomiting
- ☐ Indigestion / Reflux
- ☐ Ulcers
- ☐ Crohns / Ulcerative Colitis
- ☐ Liver Disease / Jaundice
- ☐ Gall Bladder Problems
- ☐ Bowel Disease
- ☐ Appendicitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bowel Movements / Day____
- ☐ Hemorrhoids
- ☐ Bleeding in Stools
- ☐ Abdominal Pain / Cramps
- ☐ Other Gastrointestinal Issues

Eyes

- ☐ Spots in Eyes
- ☐ Impaired Vision
- ☐ Color Blindness
- ☐ Double Vision
- ☐ Cataracts
- ☐ Glasses / Contacts
- ☐ Eye Pain / Strain
- ☐ Excessive Tearing / Dryness
- ☐ Glaucoma
- ☐ Other Eye Issues

Male Reproductive

- ☐ Testicular Pain
- ☐ Testicular Lumps
- ☐ Penile Discharge
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Veneral Disease
- ☐ Herpes
- ☐ Prostate Problems
- ☐ Other Male Issues

Social: Do You...

- ☐ Smoke
- ☐ Take Recreational Drugs
- ☐ Take Vacations
- ☐ Spend Time Outdoors
- ☐ Drink Alcohol
- ☐ Drink Coffee
- ☐ Drink Black Tea
- ☐ Exercise Regularly
- ☐ Enjoy Your Work
- ☐ Sleep Well
- ☐ Awaken Rested
- ☐ Have A Supportive Relationship
- ☐ Have Supportive Family/Friends

Health History Form

Past Injuries/Accidents: _____

_____

_____

Past Surgeries/Hospitalizations: _____

_____

_____

Current Medications/Supplements:

☐ Laxatives	☐ Pain Relievers	☐ Antacids
☐ Prednisone	☐ Cortisone	☐ Antibiotics
☐ Appetite Suppressants	☐ Tranquilizers	☐ Anti-Depressants
☐ Thyroid Medication	☐ Cardiac Medication	☐ Sleeping Pills
☐ Birth Control	☐ Hormone Replacement	☐ Allergy Medication

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

7. _____ **8.** _____

9. _____ **10.** _____

11. _____ **12.** _____

13. _____ **14.** _____

15. _____ **16.** _____

17. _____ **18.** _____

19. _____ **20.** _____

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Foods You Crave: _____

Health History Form

What Is Your Primary Complaint: _____

What Do You Think Is The Cause: _____

_____

Describe How And When Your Symptoms Began: _____

_____

_____

What Aggravates Your Symptoms: _____

_____

_____

What Eases Your Symptoms: _____

_____

_____

Do Your Symptoms Change Day/Evening/Night: _____

_____

Overall How Have Your Symptoms Progressed: ☐ Getting Better ☐ Unchanged ☐ Getting Worse

Please Explain: _____

_____

_____

Have You Had Treatment For Your Current Symptoms: ☐ Yes ☐ No

If Yes, Describe Treatment And Results: _____

_____

_____

What Are Your Goals For Therapy: _____

_____

_____

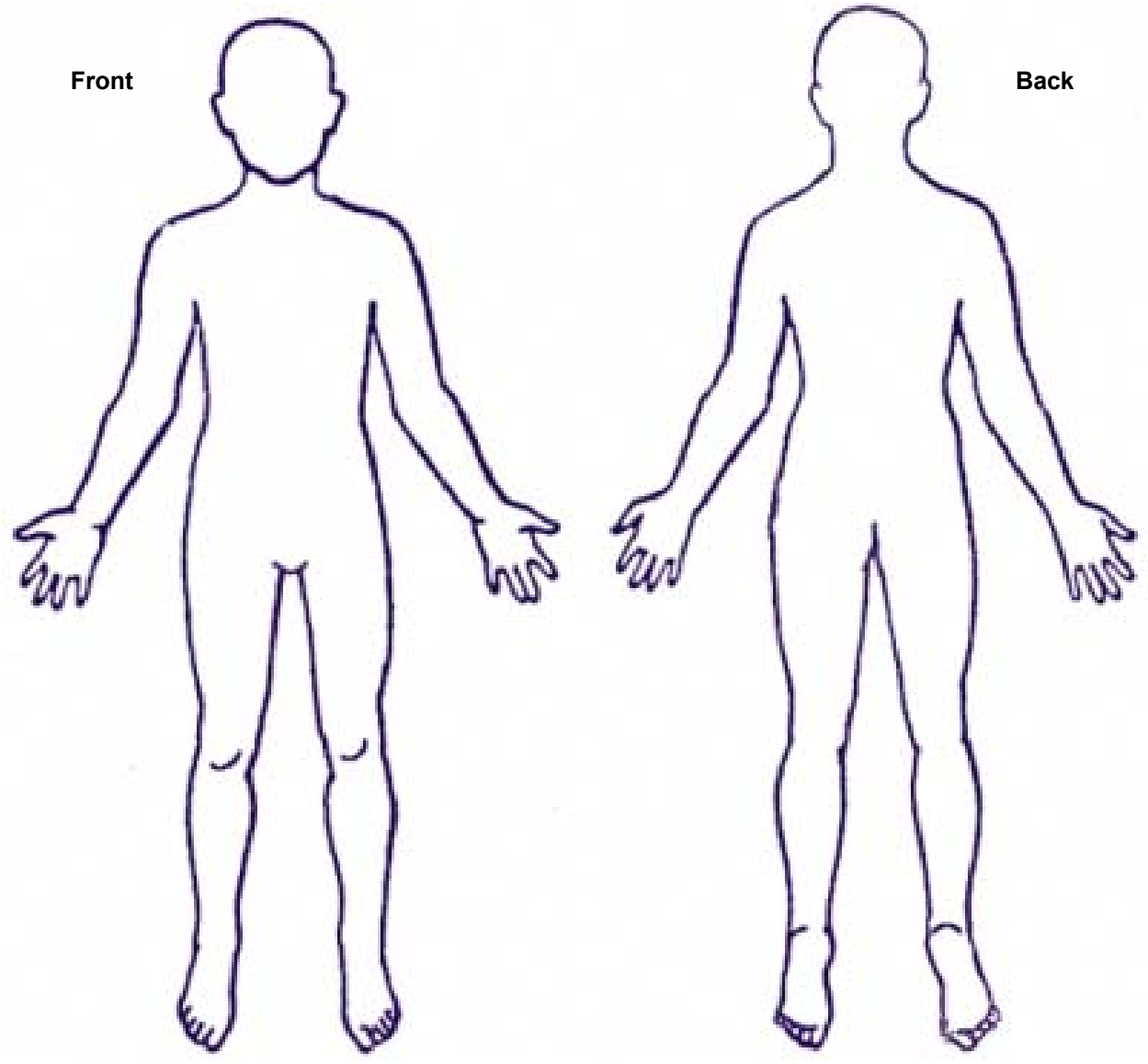
How Much Effort Are You Willing To Commit At This Time To Improve Your Health:

☐ Minimal ☐ Some ☐ Complete

Health History Form

Pain Survey: Tell Us Where It Hurts

Circle any area(s) where you are experiencing pain then rate each area on a scale of “1 - 10” with “1” being little pain and “10” being worst.



Office Use

Notes: _____

_____

_____

_____

PEMF Contraindications: Pregnant: _____ Implanted Device: _____ Active Bleeding: _____

NOTICE OF PRIVACY PRACTICES
(Required by law)

The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires that all medical records and individually identifiable health information used or disclosed by us be kept properly confidential. As required by "HIPAA", following is an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

● **Treatment** – providing, coordinating, or managing health care and related services by one or more health care providers.

● **Payment** – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

● **Health care operations** – including the business aspects of running our business, such as conducting quality assessment and improvement activities, auditing functions and customer service.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to a staff member of Wellness Northwest.

• The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to request a copy of our current *Notice of Privacy Practices* at any time.

If you feel that your rights to privacy have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

I have read and understand the above *Notice of Privacy Practices* and understand that any information regarding my health care may be used for the purposes listed above. I also understand my rights as outlined above.

Signature of Client/ Guardian:_____ Date:_____

For the treatment of minors: I hereby grant permission for therapy to be performed on this minor.

Parent Signature:_____ Date:_____

Signature:_____ Date:_____