Health History Inventory

Name _____ Date _____

1. **Health History**: Have you ever been *diagnosed* by a licensed health care practitioner for any of the following?

Tension Headaches
Migraine or Cluster Headaches
TMJ Disorder or Jaw Pain
Low Back Pain or Sciatica
Rheumatoid Arthritis
Osteoarthritis
Fibromyalgia
Tremors or Tics
Tendonitis or Bursitis
Carpal Tunnel Syndrome
Bone Fracture or Joint Sprain
Radiculopathy
Neuralgia
Peripheral Neuropathy
Shingles (Herpes Zoster)
Dermatitis, Eczema, Hives

Coronary Disorder or Heart Attack
Asthma, Bronchitis, or Emphysema
Liver Disease or Hepatitis
Urinary or Bladder Disorder
Kidney Disorder or Stones
Gall Bladder Disorder or Stones
Irritable Bowel Syndrome or Colitis
Hypertension / High Blood Pressure
Hemorrhoids or Hernia
- Diabetes Mellitus
- Thyroid Disorder
- Dysmenorrhea or Irregular Menses
- Peri- Menstrual Syndrome (PMS)
- Menopause Problems or Hot Flashes
- Prostate or Genital Disorder
- Deafness or Tinitis

- Stroke
- Tuberculosis or Pneumonia
- Brain Seizures or Epilepsy
- Concussion or Head Trauma
- Cancer or Tumors
- AIDS or HIV Disease
- Multiple Sclerosis or Palsy
- Polio or Mononucleosis
- Allergies or Hay fever
- Chronic Fatigue Syndrome
- Anorexia or Bulimia
- Attention Deficit Disorder
- Panic Attacks or Phobias
- Depression or Bipolar Disorder
- Alcohol Abuse Problems
- Substance Abuse Problems

2. **Accidents**: Have you ever been left *injured* or *impaired* by any of the following types of accidents?

- Automobile Accident
- Athletic Injury
- Work-Related Accident
- Accident in Daily Living
- Surgical Complication
- Medication Side Effect

3. **Current Conditions**: In the past 3 months, have you experienced any of the following symptoms?

- Frequent Headaches
- Chronic Back Pain or Sore Back
- Stiff or Sore Neck and Shoulders
- Pain in Elbows, Wrists, or Hands
- Pain in Hips, Knees, or Feet
- Stiff, Aching, or Swollen Joints
- Cold Hands or Cold Feet
- Frequent Daytime Sweating
- Night Sweats
- Skin Irritation or Skin Rash
- Dizziness, Fainting, or Vertigo
- Palpitations/ Rapid Heart Beats
- Shortness of Breath
- Feeling Restless or Agitated
- Chest Pain or Chest Tightness
- Abdominal Pain or Discomfort
- Abdominal Distension or Bloating
- Large Weight Gain or Weight Loss
- Overeating or Binge Eating
- Under eating or Poor Appetite
- Craving for Sweets
- Low Sex Drive
- Overworked or Overstressed
- Poor memory
- Worried About Finances or Job
- Head Congestion/ Runny Nose
- Dry Mouth or Dry Throat
- Sore Throats
- Frequent Coughs
- Fever or Malaise
- Chills or Aversion to Cold
- Nausea or Vomiting
- Diarrhea or Loose Stools
- Constipation or Dry Stools
- Blurred Vision or Dry Eyes
- Lethargy, Tiredness, or Fatigue
- Insomnia or Difficulty Sleeping
- Disturbing Dreams
- Feeling Anxious or Afraid

4. **Substances or Medications**: In the past 3 months, did you take any of the following items on a daily basis?

- 5 or more Cigarettes
- 4 or more Cups of Coffee
- 3 or more Glasses of Alcohol
- Several Aspirin or Tylenol Type Pills
- Prescribed Pain Reliever Medication
- Blood Pressure Medication
- Sleeping Pills
- Anti-Anxiety Medication
- Anti-Depressant Medication

5. **List medications, herbs, and vitamins** (include brand)

6. **List Surgeries** (continue list on back if needed)