Boost in Life

The Culture of Health, Light and Inner Peace

Medical History and Client Information Questionnaire

Name: ____ Date: ____________________

Please fill out this form as honestly and completely as you can. It will help me determine your current health, your risk factors, and create a customized treatment plan for you. If you require more space to explain, use the final page and indicate the question number.

(1)Basic Information:

Gender: Male Female Age:_____Date of Birth (month/day/year)__________/______/_________

Place of Birth:______________Height:____________Weight:___________Max weight: __________

When? _______________________

Are you currently under the care of another healthcare provider(s)? No Yes – Please list

____

(2)What are your TOP 3 concerns, in order of importance?

____

____

____

(3)Please list all medications (prescription, over-the-counter) you are currently taking:

Medication (indicate brand)	Dose/quantity per day	Why are you taking this product?

(4)Please list all natural products (vitamins, herbal medications) you are currently taking:

Natural Product (indicate brand)	Dose/quantity per day	Why are you taking this product?

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(5)Please indicate any allergies (medications, supplements, environmental, food) you have:

(6)Personal History:

Have you ever had any of the following conditions? If you check "yes", please circle if it was in the "past" or if it is a "current" concern

	Yes	No	When?		Yes	No	When?
Alcoholism/ drug addiction			Past Current	High blood pressure			Past Current
Acid reflux			Past Current	High Cholesterol			Past Current
Allergies			Past Current	Heart attack			Past Current
Anxiety			Past Current	Hepatitis			Past Current
Asthma			Past Current	Headaches			Past Current
Anemia			Past Current	Inflammatory Bowel Disease			Past Current
Arthritis/ rheumatism			Past Current	Kidney disease			Past Current
Cancer			Past Current	Osteoporosis			Past Current
Depression			Past Current	Stroke			Past Current
Diabetes			Past Current	Sleep apnea			Past Current
Eczema			Past Current	Tuberculosis			Past Current
Epilepsy/ seizures			Past Current	Thyroid disease			Past Current

If a condition is not listed above, please state any other previous or current diagnoses:

(7)Please list any condition a family member currently has or previously had:

(8)Please list all hospitalizations, accidents or surgeries, their date, and the outcome of each:

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Do you get regular screening tests done by another doctor? (Pap, blood tests) Yes No

Do you know your blood type? If so, please provide: _______________

(9)Diet:

Number of meals eaten per day: 1 2 3 more than 3 How is your appetite?

Low – never really feel hungry

Normal – feel hungry every few hours High – even after I eat I feel intense hunger

Where do you usually buy your food?_____________________Who cooks the food you eat?

____

List the primary foods included in your diet.

____

____

List the foods excluded from your diet.

____

____

List any of the following (and relative amounts) eaten regularly by you: Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods or foods you suspect may be harmful to your

health:____

_

____

List any of the foods you crave, regardless of their nutritional value (including sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.):

____

Are you satisfied with your diet as it is now?__________If not, why not?

____

____

How much water do you drink per day?

____

(10) Social History:

Occupation____Work hours____________________________

Are you: Married Separated Divorced Single Widowed Partner

With whom do live: Spouse Parents Relatives Friends Alone Other ___________________

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Do you have the support of family and friends to make positive changes in your life?

____

Have you traveled outside the U.S?__________Where and when?

____

Military Status: When did you serve?________________Where?

____

Do you have a religious or spiritual practice?

____

In what areas of your life do you experience stress? Work Family life Social life Financial life Please list the most significant stressful events of your life (remember to include childhood):

1____

2. ____

3. ____

4. ____

5. ____

What level of personal stress are you experiencing currently, if 1 = low and 10 = high?_________________________

What is your energy level, if 1 = low and 10 = high?

____

At what time of day is your energy - the best?______________________- the worst?

____

(11)Sleep

How many hours of sleep do you get per night? ____________

Do you sleep straight through the night?______If not, what time do you usually wake? _________

Solid or interrupted?____________________________What keeps you up? ___________________________

Do you have any trouble falling asleep? Yes No Do you wake feeling refreshed and well rested? Yes No

Do you have recurring dreams or nightmares ?________If yes, what is the theme?

____

What position do you usually sleep in? __________________________________

Is there a position you cannot sleep in?______If yes, which one? _____________________________________

How many pillows do you sleep on?_______Nights sweats? _______________________________________

(12)Health Habits

Do you drink alcohol?______If so, what: Wine______Beer______Other alcohol_________________________

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Do you use tobacco or have you in the past?______If so, how much? ________________________
Total number of years smoking?______Total number of years since stopped smoking?

____

Do you now or have in the past used marijuana or other drugs? _____ If yes, which drugs, how often and for how long?

____

List any long-term health problems that have resulted from taking these drugs

____

Do you exercise? ________________
How often? (Hours/day and days/week) ____
Circle any of the following that you do on a regular basis: Run Swim Walk Bicycle Garden Yoga Stretch Weights
Hike Dance. Other ____________________
Do you make time for rest, relaxation during the day and/or before bed?_____How often? ______
How do you relax?

____

What are your primary interests or hobbies?

____

(13)Environment:
Do you have any mercury fillings? No Yes – How many?

Have you ever lived near a polluted area/power line? Yes No
Are you particularly sensitive to odors (perfumes, gasoline, etc)? Yes No
Have you experienced any health problems after home renovations or having your lawn sprayed with pesticides? Yes No
Have you ever been exposed to molds, solvents, lead paint, heavy metals, fumes or other toxic substances at work, home or while traveling? Yes No (Circle all those that apply)

(14)Miscellaneous:
What obstacles do you think are keeping you from your health goals?

____

____

What do you love to do?

____

____

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(15)Review of Systems:

Please check off any symptoms that apply to you. Check "Y" if you currently have a symptom, "N" if you never had a symptom, or "P" if you had this symptom in the past.

GENERAL	Y	N	HEAD, EAR, EYES, NOSE, THROAT	Y	N
Fever/chills (circle)			Headaches/migraines (circle)		
Fatigue/weakness (circle)			Head injury		
Hot/Cold natured (circle)			Double vision		
Insomnia			Glaucoma		
Numbness			Blurry vision		
Forgetfulness			Vision changes		
SKIN, HAIR, NAILS			Eye pain		
Acne			Blind spots/blurry vision		
Boils/ulcers			Cataracts		
Change in moles			Glasses/contact lenses (circle)		
Dryness – hair, skin, nails (circle)			Dry eyes		
Eczema			Eyes bothered by sun		
Hives/rash			Nose bleeds		
Itching			Stuffy nose		
Loss of hair			Hay fever (environmental allergies)		
Night sweats			Sore tongue/mouth		
Rosacea			Infections (ears)		
Skin cancer			Earache		
Excessive sweating			Hearing loss		
Athlete's foot (fungus)			Ringing in ears		
Varicose veins			Discharge from ears		

HEAD, EAR, EYES, NOSE, THROAT CTND	Y	N	GASTROINTESTINAL CONTINIUED	Y	N
Loss of taste			Diarrhea		
Frequent colds			Blood in stool		
Frequent sore throat			Burping/passing gas		
Pain/stiffness in neck			Nausea/vomiting		
Gum problems			Change in thirst/appetite		

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Enlarged thyroid/glands			Rectal itching		
Hoarse voice			Trouble swallowing		
Dry mouth			Inflammatory bowel disease (Crohn's / colitis) (circle)		
			Indigestion/bloating		
RESPIRATORY			Intestinal worms		
Asthma			Liver/gallbladder disease		
Bronchitis/pneumonia			Jaundice (yellow skin)		
Cough			Peptic/gastric ulcers (circle)		
Difficulty breathing/Shortness of breath					
Spitting up blood			GENITOURINARY	Y	N
Sputum (phlegm)			Blood in urine		
Wheezing			Frequent urinary infections		
Tuberculosis			Inability to hold urine		
			Increased frequency		
CARDIOVASCULAR	Y	N	Frequency at night		
Palpitations, fluttering			Urgency (need to go now)		
Swollen ankles			Hesitancy (stop and go)		
Poor circulation			Pain with urination		
Cold hands/feet			Kidney stones		
Deep leg pain/cramps					
Extremity numbness/cold/swelling (circle)			MUSCULOSKELETAL	Y	N
Extremity ulcers			Arthritis/rheumatism		
Difficulty breathing/Chest pain			Back pain		
GASTROINTESTINAL	Y	N	Broken bones		
Bowel movements—how often? ____________________			Muscle spasms/cramps		
Constipation			Muscle weakness		

MUSCULOSKELETAL CONTINUED			MALE REPRODUCTIVE	Y	N
Joint pain/swelling			Hernias		

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Osteoporosis			Testicular masses/pain (circle)		
Fibromyalgia			Prostate problems		
Backache/Pain			Sexually active		
<u>NEUROLOGICAL</u>	Y	N	Sexual difficulties		
Fainting/Dizziness			Sexually transmitted infections		
Seizures/convulsions			Discharge/rash (circle)		
Involuntary movement					
Loss of balance			<u>FEMALE REPRODUCTIVE</u>		
Loss of memory			Age menses began: ________________		
Paralysis			Average days of bleeding: ________________		
Numbness/tingling (circle)			Average length of cycle: (Day 1=first day of bleeding) ________________		
Speech problems			Bleeding between cycles:		
			Birth control, if yes what type:		
<u>ENDOCRINE/HORMONAL</u>	Y	N	Difficulty conceiving		
Change in weight: specify (+/-- #lbs) ________________			Heavy menses		
			Irregular cycles		
Excessive thirst			Last menstrual period:		
Excessive hunger			Breast lumps/pain/ discharge (circle)		
Excessive urination			Number of pregnancies:		
Hot flashes			Number of live births:		
Hormone therapy			Number of miscarriages:		
Hypoglycemia (low blood sugar)			Number of abortions:		
Poor concentration			Sexually active		
Sluggish after exercise			Pain during intercourse		
Sluggish after sleep			Painful menses		
Thyroid problems			PMS: if yes, describe: ________________		
Diabetes			Sexual difficulties		

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			Vaginal discharge
FEMALE REPRODUCTIVE CONTINUED	Y	N	
Vaginal itching			
Sexually transmitted infections			
Do you do self breast exams? Yes / No			
BLOOD/LYMPHATIC	Y	N	
Anemia			
Easy bleeding/bruising (circle)			
Lymph node swelling			
EMOTIONAL	Y	N	
Anxiety/nervous tension			
Depression			
Insomnia			
Mood swings			
Difficulty dealing with anger, grief/heartbreak (circle)			

ADDITIONAL NOTES:

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Psychiatric	Y	N
Depression		
Grief		
Anxiety		
Restlessness		
Behavioral	Y	N
Exercise regularly		
Alcohol consumption		
Smoking		
Physical Abuse		
Substance Abuse		
NEUROLOGICAL	Y	N
Headaches		
Fainting		
Dizziness		
Seizures		
Numbness/ Tingling		
Loss of balance/Trouble walking		
Hematologic/Lymphatic		
Frequent bruising		
Food allergies		
Environmental allergies		
Other allergies		