

Integrative Medical Clinic

Personal Health Survey

Name: _____ Age _____

Please complete this Personal Health Survey. All practitioners at IMC will have access to this information and it will be entered electronically into your clinic record. Add pertinent information at the end of any section.

1. A brief history of your major health concern(s)
2. Your top health priority:

MEDICAL HISTORY

3. Medical Problems/issues (ck those that apply) Name of Doctor seen for this problem/when

<input type="checkbox"/> Diabetes	_____	/	_____
<input type="checkbox"/> High Blood Pressure	_____	/	_____
<input type="checkbox"/> Cancer: _____	_____	/	_____
<input type="checkbox"/> Arthritis: Joint: _____	_____	/	_____
<input type="checkbox"/> Heart Disease: _____	_____	/	_____
<input type="checkbox"/> Asthma, lung prob: _____	_____	/	_____
<input type="checkbox"/> Chronic Problem: _____	_____	/	_____
<input type="checkbox"/> Other(s) _____	_____	/	_____

4. **Allergies** to medications, foods, animals etc:

5. Women's History: Age of menarche (starting your periods) _____

Still having periods: No Yes

Regular? No Yes: Every ____ days Extra heavy flow: No Yes

PMS Symptoms? No Yes: _____

Pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____
Any problems with your pregnancies or deliveries?

6. **Medications/Herbs/Supplements** Dose/mgs/etc How many times a day

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(please check box if additional page included with medications)

7. Have you been the victim of any abuse -physical, emotional, sexual no yes
Please give brief history:

Have you ever had counseling regarding this abuse? no yes

8. Surgery History	Dates	Hospital/Town
<input type="checkbox"/> Tonsils		
<input type="checkbox"/> Appendix		
<input type="checkbox"/> Gallbladder		
<input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Ovaries		
<input type="checkbox"/> Colon		
<input type="checkbox"/> Cancer: Type:		
<input type="checkbox"/> OTHER:		

9. Injury History

Where was the injury	When was the injury	How did it happen
<input type="checkbox"/> Back_____	_____	_____
<input type="checkbox"/> Neck_____	_____	_____
<input type="checkbox"/> Knee_____	_____	_____
<input type="checkbox"/> Arms/shoulders_____	_____	_____
<input type="checkbox"/> Other_____	_____	_____

SOCIAL/WORK/HABITS

10. Alcohol : Never drink

I think, or someone else thinks, I have a problem with alcohol

Number of drinks/glasses of wine a week_____

11. Tobacco Never used

Quit _____ years ago: Smoked ___packs/day for____years

12. Drugs: Have you ever used recreational drugs: No Yes:

When:_____

Have you stopped? yes no, how much do you use:_____

13. Safety: Do you wear your seat belt regularly: No Yes

Do you have a working fire alarm in your home: No Yes

Do you have guns in the home: No

Yes: Are guns separate from bullets: Yes No

FAMILY HISTORY-

14. Have any of your immediate family members had these conditions, and what relation?

Diabetes

Heart Attack: how old?:

Cancer: Breast Ovarian Colon. Melanoma

Other:

Stroke:

Tuberculosis:

Abuse:

Other:

NUTRITION/EXERCISE/STRESS/SLEEP

15. How many glass of water do you drink a day:

What is your sleep pattern? When do you go to sleep? How long do you sleep? Do you feel rested when you wake? Do you do anything to help your sleep?

16.– Please record a THREE DAY DIET LIST – Everything you ate for three days
(Please use a separate piece of paper and include with this survey.)

Breakfast: Usual time:
What do you usually have:

Lunch: Usual time:
What do you usually have:

Dinner: Usual time:
What do you usually have:

Snacks; Usual times:
What do you usually have:

EXERCISE

17. What is your usual exercise pattern each week?

STRESS MANAGEMENT

18. What is your current stress level– 1 (mild) - 10 (extreme):
What are causes/examples of your major stresses:

How do you handle your stress, and what do you DO to manage your stress?

SPIRITUALITY/ RELIGION

19. Do you have a regular spiritual/religious practice? If so, what is it?

How does your practice impact your healing?

YOUR HEALING

20. What factors most aid or hinder your health and healing?

21. What have you deliberately changed at some time in your life? How did you do that?
How did you reward yourself for that change?

22. What habits or aspects of your health would you like to change?

What have you done to begin that change process (check all that apply):

Thought about it Planned what I would do Started doing it

Stopped for a while Restarted again

Comments:

Modalities History

Modality – used for:	Used	Helpful	Interested in trying
Acupuncture	_____	_____	_____
Biofeedback	_____	_____	_____
Chiropractic	_____	_____	_____
Body Work:type:	_____	_____	_____
Massage	_____	_____	_____
Psychotherapy	_____	_____	_____
Nutrition	_____	_____	_____
Naturopathic Med	_____	_____	_____
Energy work:type	_____	_____	_____

SYMPTOM REVIEW – Please note any problems or symptoms you have in the following:

Eyes, Ears, Nose or Throat: Ringing in ears?

Headaches?

Respiratory : Cough, Wheezing, Shortness of Breath?

Heart: Chest pain, irregular heart rate??

Digestive: Constipation, Diarrhea, Bloating, Black stool or blood in stool?

Skin :

Urination problems?

Neurologic: numbness or tingling in hands or feet? Unsteadiness? Dizziness?

Emotional / Psychological concerns? Do you feel sad? Do you feel depressed?

What else should we know about your health?