2 Degrees North, LLC

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Health History Form

This information is confidential and will only be released with your signed consent.

Full Name: _____ Today's Date: _____

Address: _____ E-mail: _____

_____ Best way to contact you: Phone Voicemail E-mail

Phone: (C) _____ (H) _____ (W) _____

Birthdate: _____ Age: ___ Sex: ____ Gender Id/Pronoun(s): _____ Height: _____ Weight: ____ Occupation: _____

Legal Status: Single Married Divorced Separated Widowed Living Situation: _____

Education (last completed): ☐Elementary ☐HS ☐College ☐Grad school ☐Vocational ☐Prof ☐Post-Grad

Emergency Contact: _____ Relationship: _____ Phone #: _____

If under 18, parents name(s)/address(es): _____

How did you hear of us / referred by? _____

Primary Physician: _____ Other Physicians/Specialists: _____

Other Alternative Health Care Practitioners: _____

The main reason(s) for my visit today are: _____

_____

Family Health History

☐ *Check here if family history is unknown*

	Age	If dead, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check the following items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

Yes		Relationship
☐	Alcohol/drug problem	
☐	Allergy/asthma	
☐	Anemia	
☐	Arteriosclerosis	
☐	Arthritis	
☐	Binge eating/bulimia	
☐	Cancer	
☐	Diabetes	
☐	Epilepsy/seizures	
☐	Gonorrhea	
☐	Heart disease	
☐	Other not mentioned	

Yes		Relationship
☐	High blood pressure	
☐	High cholesterol/fat	
☐	Kidney disease	
☐	Liver disease	
☐	Mental illness	
☐	Obesity	
☐	Skin disease	
☐	Suicide	
☐	Syphilis	
☐	Thyroid disease	
☐	Tuberculosis	
☐	Ulcers	

Past History of Illness and Medical Problems

Surgery: List all surgery	When	Other hospitalizations	When

Broken bones and/or traumatic injuries include all car accidents or concussions	Dates	Major health complaints and duration	Duration

Past History

Yes	When	Yes	When	Yes	When
☐ Acne		☐ Fibroids		☐ Periodontal disease	
☐ AIDS/HIV		☐ Gallbladder problems		☐ Phlebitis	
☐ Alcohol/Drug problem		☐ Glasses/contacts		☐ Pneumonia	
☐ Allergies		☐ Glaucoma		☐ Premenstrual tension	
☐ Amalgams/silver fillings		☐ Gonorrhea		☐ Prostate problems	
☐ Anemia		☐ Gout		☐ Psychotherapy	
☐ Antibiotics more than once a year		☐ Hay Fever		☐ Reactions to vaccinations	
☐ Anxiety		☐ Hearing Problem		☐ Rheumatic fever	
☐ Arteriosclerosis		☐ Heart attack		☐ Root canals	
☐ Arthritis		☐ Heart failure		☐ Scarlet fever	
☐ Asthma		☐ Heart problem		☐ Sexually transmitted disease	
☐ Back pain/strain		☐ Hemorrhoids		☐ Sinusitis	
☐ Binge eating		☐ Hepatitis		☐ Skin problem	
☐ Bladder infection		☐ Herpes		☐ Sleep disorder	
☐ Blood clots		☐ Hiatal Hernia		☐ Stroke	
☐ Breast fed		☐ High blood pressure		☐ Suicide attempt	
☐ Breast lump		☐ High cholesterol/ triglycerides		☐ Syphilis	
☐ Bronchitis		☐ Histoplasmosis		☐ Taken steroid (cortisone/prednisone)	
☐ Bulimia (self-induced vomiting)		☐ Hives		☐ Thyroid problem	
☐ Cancer		☐ Hypoglycemia		☐ Tonsillitis	
☐ Cataract		☐ Infectious Mononucleosis		☐ Tooth problems	
☐ Chemical sensitivity		☐ Insomnia		☐ Tuberculosis	
☐ Chicken Pox		☐ Kidney infection		☐ Urine problems	
☐ Chronic fatigue		☐ Kidney stones		☐ Vaginitis	
☐ Coccidiomycosis		☐ Kidney problems		☐ Vision problems	
☐ Colds, frequent		☐ Liver disease		☐ Warts	
☐ Colitis		☐ Measles		Other problems	
☐ Congenital defect		☐ Menstrual problems		☐	
☐ Counseling		☐ Mental Illness		☐	
☐ Depression		☐ Migraine		☐	
☐ Diabetes		☐ Mumps			
☐ Ear Infection		☐ Nervous condition			
☐ Eczema		☐ Neurological problems			
☐ Endometriosis		☐ Nightmares—frequent			
☐ Epilepsy		☐ Overweight >20lbs			
☐ Epstein Barr		☐ Pelvic infection			
☐ Fibrocystic Breasts		☐ Peptic ulcer			

Personal History

Current Medications (prescription and non prescription)

Vitamin & Mineral supplements (type & Dosage)

Allergies:
I am allergic to the following medications, foods, chemicals or inhalants:

Lifestyle:
List your favorite foods or cravings:

I do the following for relaxation/recreation/fun/interest:

Activity	Frequency

I usually eat:
☐white bread ☐whole grain bread
I usually buy:
☐fresh ☐frozen ☐canned vegetables
I usually eat my vegetables:
☐raw ☐steamed ☐boiled ☐sautéed
I usually eat:
☐fresh ☐frozen ☐canned fruits
I eat beef or pork:
☐at least once a day ☐five times a week ☐less than three times a week ☐never
I usually prepare my meats and fish:
☐pan fried ☐deep fried ☐baked ☐broiled ☐grilled
I sweeten food with: ☐sugar ☐artificial sweeteners ☐stevia
☐honey ☐ maple syrup ☐ none
My salt use is:
☐none added ☐light ☐moderate ☐heavy
I drink water:
☐city ☐well ☐spring ☐filtered _____ glasses a day.
I break from eating 8 10 12 14 16 hours, _____days per week.

To control my weight, I have used:
☐fasting: intermittent 1-4 days longer ☐diet pills ☐laxatives
☐self-induced vomiting ☐enemas ☐diuretics ☐health/diet
☐exercise ☐other _____

I am now or have been a smoker: ☐yes ☐no
How many years have you smoked? _____
When did you quit? _____
What do you smoke now? _____
How much? _____

I estimate my use of:
coffee: ___ cups/day decaf: ___cups/day
tea: ___ cups/day soda: ___ cans/day
I use ☐beer ☐wine ☐ "hard" liquor
I consider myself a:
☐non-drinker ☐social drinker ☐heavy drinker ☐alcoholic ☐recovering alcoholic
I use: ☐marijuana ☐other drugs: _____
I have wondered about counseling or medical care for my use of:
☐alcohol ☐tobacco ☐food ☐drugs.

I have participated in an exercise program: ☐yes ☐no
I exercise now on a regular basis: ☐yes ☐no
I think I get enough exercise: ☐yes ☐no
I would like to do more exercise: ☐yes ☐no Note: _____

I find my work:
☐too demanding ☐boring ☐satisfactory ☐very satisfying
My sex life is satisfactory: ☐yes ☐no Libido: (scale 1-10) _____

I am sometimes fearful of:

☐ being alone	☐ darkness
☐ robbers	☐ sudden noises
☐ high places	☐ the unknown
☐ animals/bugs (specify):	☐ other (fire, accidents, etc):
I worry about:	☐ job /work
☐ money / security	☐ family / family life
☐ relationships	☐ other:

I sleep well: ☐yes ☐no Describe: _____

I currently see a psychotherapist or other mental health professional:
☐yes ☐no

I have had a therapeutic massage: ☐yes ☐no
I currently see a chiropractor, osteopath, rolfer, massage therapist or other body work professional. ☐yes ☐no Note: _____
I have been arrested: ☐yes ☐no Note:_____
I have been in the military ☐yes ☐no
I have been a victim of abuse: ☐physical ☐emotional ☐sexual
Notes: _____

My spiritual life is satisfactory: ☐yes ☐no
I am currently involved in a regular spiritual program ☐yes ☐no

My last physical exam was _____

Life Changes

In the last 12 months, what changes have occurred in your life?

Personal Life

Family Life

Social Life

Work Life

Sex Life

Any other significant changes

Lifestyle Comments

How do you feel when you wake up in the morning?

How often to you ordinarily eat (snacking included) during a 24 hour period?

Please add anything that you would like to tell us that has not already been covered.

Review of Systems

Answer "yes" if you have had these symptoms **in the past 12 months**

Yes

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food cravings
- ☐ Frequent infections
- ☐ Night Sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Unusual hair loss/growth
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headaches
- ☐ Dizziness
- ☐ Balance problems
- ☐ Head injury
- ☐ Seizure/convulsions
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing/itching
- ☐ Eye pain
- ☐ Dark circles under the eyes
- ☐ Date last eye exam
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breathing
- ☐ Chronic cough
- ☐ Bloody/yellow sputum

Yes

- ☐ Shortness of breath
- ☐ with exertion
- ☐ at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High blood pressure
- ☐ Chest pain or pressure
- ☐ at rest
- ☐ with exertion
- ☐ with stress
- ☐ with eating
- ☐ down left arm, neck or back
- ☐ accompanied by nausea, sweating, anxiety
- ☐ Irregular heartbeat
- ☐ Skipped heartbeats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Pain or fatigue in legs with exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Difficulty swallowing
- ☐ Pain/discomfort when eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Pain relieved by eating
- ☐ Nausea/vomiting
- ☐ Trouble with fried foods
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay-colored stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning during urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Loss of control/urine

Yes

- ☐ Foul odor to urine
- ☐ Low back pain
- ☐ Muscle pain
  Where:
- ☐ Muscle weakness
  Where:
- ☐ Joint pain
  Where:
- ☐ Joint pain aggravated by motion
- ☐ Joint pain relieved by motion
- ☐ Swollen joints
- ☐ Stiff joints

MEN

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt urine stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

WOMEN

Last menstrual period
Age began menstruation
Age at menopause
# of pregnancies
# of live births
# of abortions/miscarriages
Usual length of cycle days
Usual length of period days
Date of last Pap smear

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility
- ☐ Breast fed a baby