River City Wellness

Health History Paperwork

Welcome to River City Wellness: It is my goal to help each and every patient improve their quality of life and achieve optimum health. In order to provide you with the most effective care possible, I encourage you to fill out the paperwork in detail and as accurately as possible. All symptoms you experience are relevant and make up a complete picture of your health physically, emotionally and mentally. Thank you.

Personal Information

Name: _____ Date of Birth: _____/_____/_____

Address:_____ City:_____ Zip:_____

Phone #: _____ Email: _____

How did you hear about River City Wellness: _____

Primary Care Provider:_____ _____

Please list all medications, herbs, vitamins or supplements you currently take:_____

_____

General Health Information

Main Health Complaints How are you affected?

1. _____ _____

2. _____ _____

3. _____ _____

Any medical diagnosis? _____

Any secondary health complaints: _____

_____

Do you have an infectious disease? Yes No If yes, please identify:_____

History of Illness, Trauma, Surgery or Accident (please list age and any hospitalizations)

Childhood: _____ :_____

_____

Adolescence: _____

_____

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Adulthood: _____

_____

_____

Do you have any scars? If yes, please note location and reason: _____

_____

Medical Conditions (Please circle all that apply to you):

* Per the state of Kentucky, items indicated iwth asterisk require the care of a primary physician.

Diabetes *	Tuberculosis	Autoimmune
Hypertension *	Suspected fracture *	HIV
Thyroid disorder	Acute Respiratory Disease *	Mood disorder
Hepatitis	Undiagnosed Neurological Changes *	Mental illness
Acute Severe Abdominal Pain *	Unexpected Weight loss	Anemia
Heart Disease *	Bleeding or hemorrhage	
Cancer *	Suspected Systematic infection *	

- Do you typically eat at least 3 meals per day? Y N If no, how many?_____
- Do you feel you need help eating healthier? Y N
- Do you have any food cravings? _____
- Carbonated drinks: _____/day Glasses of water: _____/day Cups of caffeine: _____/day
- Alcohol drinks: _____/day or week Do you use nicotine: Y N If yes, how much: _____/day
- Average hours of sleep per night: _____ Do you wake rested? Y N

  Dreams/Nightmares Trouble falling asleep Trouble staying asleep
- Occupation: _____ #Hours/Week: _____

  Do you enjoy work? Y N Why/ Why not? _____
- Do you feel stressed? Y N What creates stress in your life? _____

  Have you been through a period of continual stress? If so, when, why, and for how long? _____

  _____

  _____

  _____
- Interests/hobbies: _____

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Please CHECK any symptoms that you have now and UNDERLINE any you have experienced in the past.

Endocrine System (Kidney Organ System)

o Hypothyroid
o Hypoglycemia
o Hyperthyroid
o Feeling hot or cold
o Cold hands or feet
o Hot flashes
o Night sweats
o Fatigue
o Infertility
o Menstrual Irregularities

Respiratory (Lung and Kidney System)

o Pneumonia
o Frequent colds
o Persistent cough
o Sneezing
o Allergies
o Asthma
o Fatigue
o Sinus congestion
o Bronchitis
o Sore throats
o Skin conditions
o Post nasal drip
o Difficulty breathing
o Shortness of breath

If you are a smoker, # of cigarettes per day _____ Years smoked _____ Do you want to quit? Y N

Head, Eyes, ENT (Blood function and Liver, Heart, and Spleen Systems)

o Blurry vision
o Eye pain/strain
o Glaucoma
o Glasses/contacts
o Tearing/dryness
o Floaters
o Dizziness
o Earaches
o Tinnitus
o Sinus problems
o Congestion
o Post nasal drip
o Teeth grinding
o TMJ
o Headaches
o Poor memory
o Poor concentration

Cardiovascular (Heart System)

o Heart diease
o Chest pain
o Palpitations
o Stroke
o Heart murmur
o Shortness of breath
o Varicose veins
o Arrhythmia
o Tachycardia
o Anemia
o Anxiety
o Cold hands/feet
o Depression
o Forgetfulness
o Tongue ulcers
o Insomnia
o Vivid dreaming
o Ankle swelling
o High blood pressure
o Low blood pressure

Gastrointestinal (Spleen and Stomach Systems)

o Stomach ulcers
o Strong appetite
o Weak appetite
o Nausea
o Vomiting
o Gas
o Heartburn/reflux
o Belching
o Abdominal pain
o Bloating
o Noisy intestines
o Bruise easily
o Hemorrhoids
o Atherosclerosis
o Stomach ache
o Bad breath
o Bleeding gums
o Fatigue after meals
o Food cravings

Elimination Function (Intestine Systems)

o Constipation
o Effort to eliminate
o Incomplete stools
o Diarrhea
o IBS
o Polyps
o Blood in stools
o Mucous in stools
o Frequent UTI
o Kidney disease
o Painful urination
o Impaired urination
o Blood in urine
o Kidney stones

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Please CHECK any symptoms that you have now and UNDERLINE any you have experienced in the past.

Neurological

o Vertigo / Dizziness
o Paralysis
o Numbness
o Tingling
o Loss of Balance
o Seizures

Autoimmune and Inflammatory Conditions

o Hashimoto's
o Rheumatism
p Lupus
o Colitis
o Crohn's
o Allergy
o Food allergy
o Arthritis
o Tendonitis
o Lyme
o Endometriosis
o Chronic fatigue
o Fibromyalgia
o Celiac's
o Interstitial cystitis
o Multiple sclerosis
o Psoriasis
o Eczema

Female Reproductive

o Irregular cycles
o Breast tenderness
o Heavy flow
o PMS
o Clotting
o Cramping
o Emotional reactions
o Menopause
o Infertility
o Low libido

Do you have any reason to believe you are pregnant? Y N If so, how are along are you? _____

Age of first menses: _____ Length of cycle: _____ days Length of menses: _____ days

# of pregnancies: _____ # of miscarriages: _____ # of live births: _____

Birth control type: _____

Male Reproductive

o Sexual difficulties
o Prostate problems
o Testicular pain[
o Discharge
o Infertility

Musclo-skeletal (Liver, Kidney, and Spleen systems)

o Pain - where in the body (list joints or areas affected): _____
_____
_____

o Tendonitis / Arthritis (list joins affected): _____
_____

o General tension - where: _____
_____

o Muscle spasms / cramps - where: _____
_____

o Weakness in the body - where: _____
_____

o Spinal problems - please list: _____
_____

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