Personal Health History

Name: ____ **DOB**: ________________ **Today's Date**: ____________

Address: ____

Email: ____ **Phone**: ________________________________ **Text Y/N**

Occupation: ___________________________________ **Referred By**: ____________________________________

Primary Health Concerns:

1) ______________________________________ 3) ______________________________________

2) ______________________________________ 4) ______________________________________

FAMILY HEALTH HISTORY

Please list any major health issues for the following blood relatives of the client.

Alcohol/drug problem, Allergy/Asthma, Anemia, Arteriosclerosis, Arthritis, Binge Eating/Bulimia, Bleeding Problem, Cancer, Diabetes, Epilepsy/seizure, Heart Disease, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Mental Illness, Obesity, Stroke, Suicide, Thyroid Disease, Tuberculosis, Ulcer, Syphilis, Skin Disease, Gonorrhea, other…

PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	FATHER	MOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER

HISTORY OF CLIENT ILLNESS, INJURY, AND MEDICAL PROCEDURES:

Hospitalizations: Reasons/Dates

____

Surgeries: Procedures & Approximate Dates

____

Serious Illnesses:

____

Accidents/Traumatic Injuries/Broken Bones:

____

Current Medical Diagnoses:

____

CURRENT MEDICATIONS/SUPPLEMENTS	TREATMENT FOR	YEAR/DATE STARTED
____________________________________	____________________	____________________
____________________________________	____________________	____________________
____________________________________	____________________	____________________
____________________________________	____________________	____________________
____________________________________	____________________	____________________
____________________________________	____________________	____________________

HEALTH CONDITIONS

Please check all that apply to you and list approximate dates/years.

Acne	Endometriosis	Overweight
AIDS	Fibroids (uterine)	Panic Attack
Alcohol/Drug Problem	Gallbladder	Pelvic Infection
Allergies	Glaucoma	Periodontal Disease
Anemia	Gout	Phlebitis
Antibiotics (>/= 1x a year)	Hearing Problems	Pneumonia
Anorexia/Bulimia	Heart Attack	Premenstrual Tension
Anxiety	Heart Failure	Prostate Problems
Arthritis	Hemorrhoids	Psychotherapy
Asthma	Hepatitis	Rheumatic Fever
Back Problems	Herpes	Scarlet Fever
Binge Eating	Hernia	Seizures/Epilepsy
Bladder Infections	High Blood Pressure	Sexually Transmitted Infections
Blood Clots	High Cholesterol	Sinusitis
Breast Lumps	Hives	Sleep Disorder
Bronchitis	Insomnia	Steroid Use
Cancer	Kidney Infections/Stones	Stroke
Cataract(s)	Liver Disease	Suicide Attempt
Chemical Sensitivity	Menstrual Problems	Syphilis
Chronic Fatigue	Mental Illness	Thyroid Problem
Colitis	Migraines	Tuberculosis
Depression/Anxiety	Mononucleosis	Ulcer
Diabetes	Mumps	Vaccine Reaction
Ear Infections	Neurological Problems	Warts
Eczema	Nightmares/Night Terrors	

Jenna Dodge | jennadodge.com | jenna@jennadodge.com | 406.581.0459

MALE	FEMALE
Enlarged Prostate?	Date of Last Menstrual Period
Decreased Urine Stream?	Length of Cycle
Unable to Interrupt Stream?	Length of Period
Dribbling After Urination?	Age Menstruation Began
Pus or Drainage from Penis?	Menopause?
Genital Swelling?	Number of Pregnancies
Rash/Eruptions?	Number of Live Births
Problems with Sexual Function?	Number of Abortions/Miscarriages
	Vaginal Discharge?
	Spotting Between Periods?
	Painful Intercourse?
	Issues with Fertility?
	Problems with Sexual Function?

LIFESTYLE

Allergies	**Food Allergies (include method of testing)**
Food Cravings	**Alcohol/Recreational Drug Use—**Do you drink alcohol or use drugs? How much/often?

Caffeine—Do you drink coffee or tea? How much/often?	**Cigarettes—**Do you smoke now or did you in the past? How much/often?
Diet Soda/Artificial Sweeteners—Describe your use:	**Refined Sugars/Processed Foods—**Describe your use:
Hobbies—List any. How often do you do them?	**Living Situation**
Exercise—Describe the ways you get your body moving. Do you feel you get enough physical activity?	**Food—**Do you feel you eat a healthy and well-balanced diet? Do you need guidance/support?
Worry/Anxiety—Do you have particular issues that worry you? How does this impact your life?	**Healthy Relationships—**Do you have a supportive family/community?
Unhealthy Relationships—Have you been a victim of domestic abuse or troubling relationships?	**Intimacy—**Are you satisfied with your sexual/intimate life?

Anything else? Please indicate any topics you want to address in your consultation or for anything you'd like to add.

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