

# Client Health History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: M/F

Marital Status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Height: \_\_\_\_\_

Weight: Currently: \_\_\_\_\_

Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

Pulse: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Other: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

What brings you to ICAM? \_\_\_\_\_

1. Please identify the health concerns that have brought you to ICAM in order of importance below:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

\_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

\_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

\_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

d. \_\_\_\_\_

\_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

2. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction)

\_\_\_\_\_  
\_\_\_\_\_

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

4. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

a. Past pregnancies: Age: \_\_\_\_\_  
Age: \_\_\_\_\_  
Age: \_\_\_\_\_  
Age: \_\_\_\_\_

5. Do you have any infectious diseases? Y N If yes, please specify: \_\_\_\_\_

6. **Family History:**      Father                  Mother                  Brothers                  Sisters                  Spouse                  Children

Check those applicable:

Age(if living)	_____	_____	_____	_____	_____	_____
Health(G=good P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____
Other	_____					

7. **Childhood Illness** (please circle any that you have had):

Scarlet Fever    Rheumatic Fever    Mumps    Measles    German Measles    Chicken pox

8. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood swings    Nervousness    Mental Tension

9. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past)

Fatigue    Slow wound healing    Chronic Infections    Chronic Fatigue Syndrome

10. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ Problems	Hay Fever

11. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent common colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

12. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

13. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas
Heartburn	Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C
Hemorrhoids	Abdominal Pain			

14. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

15. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

16. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge
---------------------	-------------------	--------------------------	------------------

17. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain    Muscle Spasms/Cramps    Arm Pain    Upper Back Pain  
Mid Back Pain    Low Back Pain    Leg Pain    Joint Pain (where?) \_\_\_\_\_

18. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

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

19. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid    Hypoglycemia    Diabetes Mellitus    Night Sweats    Feeling Hot or Cold

20. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia    Cancer    Rashes    Eczema/Hives    Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

21. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N    If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? Y N  
Do you fall asleep quickly? Y N    Do you sleep through the night? Y N

e. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Do you enjoy work? Y N    Why/Why not? \_\_\_\_\_

f. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

g. Have you experienced any physical or emotional traumas? Y N  
Explain: \_\_\_\_\_  
\_\_\_\_\_

h. How much water do you drink per day? \_\_\_\_\_

i. Do you have a bowel movement every day? Y N

**22. Dental History:**

- a. Do you have any silver(mercury) fillings? Y N
- b. Do you have any root canals? Y N
- c. Do you have any implants? Y N
- d. Have you had any extractions done? Y N

**Which teeth? Date**

---

---

---

---

**23. Surgery/Hospitalizations                      Age**

---

---

---

---

---

**24. Toxic profession/Exposure past or present**

---

---

---

**25. Please write down the location of any scars on your body**

**Location    Date/Reason**

---

---

---

---

**26. Please write down any other information that you believe is important for us to know.**

---

---