

Axis Natural Medicine

Health Questionnaire

Please complete this questionnaire carefully. All information will be held in absolute confidence.

Name _____ Date _____
Address _____ Social Security Number _____
_____ Date of Birth _____ Age _____
Phone - Home _____ Place of Birth _____
Phone - Alternate _____ Height _____ Weight _____
E-Mail _____ Referred by: _____
Emergency contact _____ Relationship _____

Main Problem(s) _____

Does this problem interfere with daily activities? Please explain. _____

What makes this better or worse? _____

Personal History: (check all that apply, note history & treatment)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Family Medical History (Please identify the family member's relation to you)

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Surgeries: (Please include date) _____

Significant Trauma (please include date): _____

Hospitalizations _____

Medicines, Vitamins, Herbs, Supplements taken within the last two months _____

Allergies: (Causes, symptoms, discomforts) _____

Significant Illness (childhood & adulthood) _____

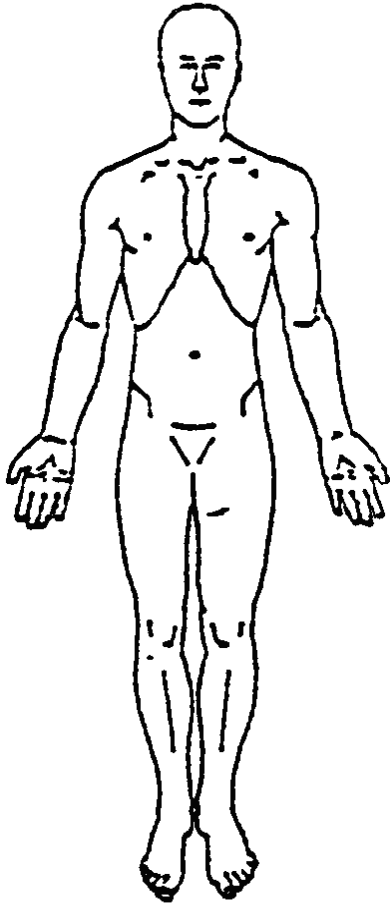
Immunizations _____

Personal Habits (please include amount & frequency)

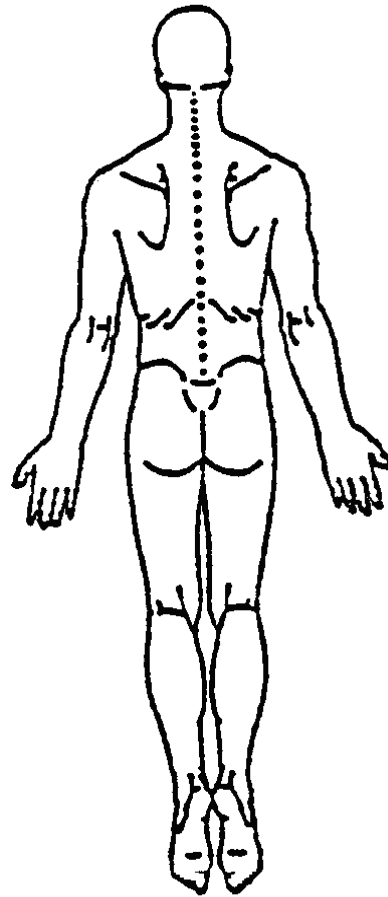
Coffee _____ Alcohol _____ Tobacco _____ Recreational Drugs _____

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Indicate Painful or Distressed Areas. Explain as fully as possible.



XXX pain
 ::: numbness



Please explain if you have had any of the following within the last 3 months

GENERAL

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sweating Easily |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Poor Sleep / Trouble Sleeping | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Peculiar Tastes or Smells |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sudden Energy Drop: Time of Day _____ | |

SKIN & HAIR

- | | | |
|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Itches | <input type="checkbox"/> Dryness | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Recent Moles | Other _____ |

EYES, EARS, NOSE & THROAT

- | | | |
|---|--|--|
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nasal Stuffiness |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Sinusitis/Rhinitis |
| <input type="checkbox"/> Redness in Eyes | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Teeth Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sores on Lips or Tongue |

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HEAD & NECK

- () Migraines () Dizziness () Goiter
() Concussion(s) () Lumps () Swollen Glands

Headaches/Migraines - where & when _____

Other head or neck problems _____

RESPIRATORY

- () Cough () Coughing Up Blood () Asthma
() Bronchitis () Pneumonia () Pain with Deep Breaths
() Difficult Breathing When Lying () Phlegm - Color _____ () Wheezing

Other Lung Problems _____

CARDIOVASCULAR

- () High Blood Pressure () Low Blood Pressure () Chest Pain
() Irregular heartbeat () Murmur () Fainting
() Cold Hands or Feet () Swelling of Hands/Feet () Palpitations
() Blood Clots () Phlebitis () Difficulty in Breathing

Other Heart or Circulatory Problems _____

PERIPHERAL VASCULAR & HEMATOLOGIC

- () Intermittent Claudication () Anemia () Past Transfusion
() Varicose Veins () Bleed or Bruise easily

GASTROINTESTINAL

- () Indigestion () Poor Appetite () Diarrhea
() Nausea () Changes in Appetite () Constipation
() Vomiting () Cravings (circle all that apply) () Black Stools
() Heartburn sugar salt sour spicy () Hemorrhoids
() Belching () Jaundice () Blood in Stools
() Bad Breath () Changes in Bowel Movements () Gas

() Abdominal Pain or Cramps Other Stomach or Intestinal Problems _____

URINARY

- () Pain on Urination () Frequent Urination () Blood in urine
() Urgent Urination () Unable to Hold Urine () Urinary Tract Infections
() Decrease in Urine Flow () Kidney Stones Other _____
() Waking at night to Void - How Often _____ Color of Urine _____

GENITO-REPRODUCTIVE

FEMALES

- Pregnancies _____ Birth Control Type & Length of Use _____
Births _____ Date of Last menses _____ () Irregular Periods
Miscarriages _____ Length of Menses _____ () No Periods
Abortions _____ Days Between Menses _____ () Breast Lumps or Pain
Last PAP _____ Flow () Heavy () Light () Chronic Yeast Infections
First Menses _____ Clots () Dark () Red () Menopause - Age _____
Pain with Cycle () Beginning () Ending () Ovulation () Bleeding after Intercourse
PMS () Psyche () Body

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Vaginal Discharge/Leukorrhea - please describe _____

MALES

- | | | |
|---|--|---|
| <input type="checkbox"/> Sores on Genitals | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Excessive/Decreased libido |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Hernias | <input type="checkbox"/> Discharge from penis |

MUSCULOSKELETAL

- | | | |
|---|--|--|
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Foot/Ankle Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Hip Pain |

Other Joint or Bone Problems _____

NEUROPSYCHOLOGICAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Excessive Stress | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Paralysis |

Have you been treated for emotional problems? _____ Have you considered or attempted suicide? _____

ENDOCRINE

- | | | |
|---|---|--|
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Strong Thirst |

If There Is Anything Else You Would Like To Discuss With Your Physician,

Please Include A Detailed Description Below.
